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ONCOLOGY ISSUES

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March | April 2018

Developing an Acuity Tool to Optimize Nurse Navigation Caseloads





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- Brad Bott, MBA, CCRP, director, Oncology Clinical Program, Intermountain Healthcare

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The Official Journal of the
Association of Community Cancer Centers

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Oncology Issues serves the multidisciplinary specialty of oncology care and cancer program management.

Oncology Issues (ISSN: 1046-3356) is published bimonthly for a total of 6 issues per year by Taylor & Francis Group, LLC, 530 Walnut Street, Suite 850, Philadelphia, PA 19106, on behalf of the Association of Community Cancer Centers (ACCC), 1801 Research Blvd, Suite 400, Rockville, MD 20850-3184, USA. US Postmaster: Please send address changes to *Oncology Issues* c/o Taylor & Francis Group, LLC, 530 Walnut Street, Suite 850, Philadelphia, PA 19106. Copyright © 2018 by the Association of Community Cancer Centers. All rights reserved. No part of this publication may be reproduced, stored, transmitted, or disseminated in any form or by any means without prior written permission from the publisher, Taylor & Francis Group, LLC.

Straight from the Source

BY JENNIE R. CREWS, MD, MMM, FACP



In a survey on direct-to-consumer (DTC) advertising highlighted in “Fast Facts” on pages 4-5, the majority of physicians surveyed believe that this type of advertising increases confusion and misunderstanding by patients. Still, most physicians advocated for reforming rather than banning DTC advertising. This “don’t throw the baby out with the bath water” response raises important questions about the available data we have on the benefits and risks of DTC advertising and what role the multidisciplinary cancer care team can play to ensure that those benefits outweigh the risks.

Some of the controversy surrounding DTC advertising is due to the rising costs of drugs and the criticism that spending for advertisement contributes to this cost. After loosening of regulations in 1996, pharmaceutical media spending peaked in 2006 at \$5.41 billion but has declined slightly to \$4.34 billion as of 2010.¹ Yet for every 10 percent increase in DTC advertising, there is a 1 percent increase in prescription drug spending.²


Arguments in favor of DTC advertising for patients include patient empowerment, improved communication between patient and provider, and increased appropriate use of medications. Some advocate that DTC advertising particularly benefits those with healthcare disparities who can use the information to initiate a conversation they may not otherwise have with their healthcare team. Though these arguments sound reasonable, there is little data to support these claims.

Arguments against the use of DTC advertising include added costs to healthcare, detriment to the physician-patient relationship, time management burden to the healthcare team, and inappropriate prescription recommendations. The latter seems to be more of an issue in non-oncology prescribing, but there are data to suggest that

DTC advertising can impair the provider-patient relationship. One survey showed that patients who were provided information via DTC advertising rather than from their provider were 11.3 percent less confident in their provider.³ Oncology care teams are also concerned about patients misinterpreting benefits and risks.

We are all familiar with DTC advertising campaigns for checkpoint inhibitors, which raise patient hopes and expectations for very expensive therapies that have very real toxicities. How do we apply lessons learned from previous experience to these newer agents? What are the ways in which we can maximize benefit and reduce risk to patients and to our teams?

One way is through advocating for regulation of DTC advertising, focusing on the type of advertisement used. DTC advertising as a means of patient education and empowerment can be achieved by primarily using a help-seeking form of DTC advertising, which provides information about a condition or treatment but does not include specific drug information. Companies could still promote brand awareness through sponsorship but may be inclined to invest less in this form of DTC advertising, which would address the cost issue. Social media is another area of opportunity for reform. Oncology teams have an opportunity to be active on social media and drive patients toward the unbranded information we can provide.

Finally, we can continue to do what we do best—have conversations with patients so that they can make an informed decision that is right for them. 

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Looking Back

BY MARK S. SOBERMAN, MD, MBA, FACS



It has been a year of turmoil and uncertainty for cancer care providers. Political battles and ideological disagreements have the potential to diminish the percentage of

Americans with health insurance, threatening their access to care. The transition from fee-for-service, volume-based reimbursement to value-based reimbursement has progressed in fits and starts. New cancer treatments, though offering the hope of better outcomes and improved survival, came with increased cost and previously unheard-of toxicities. Patient financial challenges loom large, even coining a new phrase in the cancer lexicon—*financial toxicity*. At the same time, the cancer workforce faces unprecedented shortages; in so many ways, we are pressed to do more with less.


It would be easy enough to be discouraged by the various challenges we face as cancer care providers. However, experience has taught me that when faced with challenges, healthcare professionals respond with imagination, innovation, and dedication.

The theme of my year as ACCC president has been “Envisioning the Next Generation Multidisciplinary Cancer Care Team.” As we explored this theme at our national meetings and the Institute for the Future of Oncology, I have consistently been impressed and encouraged by the creative ideas and solutions proposed by our diverse group of stakeholders to address the challenges of workforce shortages, the increasing complexity of care,

the cost of care, new reimbursement systems, and the imperative to improve communication and coordination among care team members.

It is estimated that ACCC members care for 65 percent of the cancer patients in the United States. At the 2017 ACCC National Oncology Conference in Nashville this past year, one of our keynote speakers stated that it was a privilege to care for patients with cancer. I echo that sentiment. This is my last column as ACCC president, and it has been an honor and privilege to serve as its president for the past year.

ACCC is a remarkable organization that includes a large, diverse, and uniquely representative group of stakeholders. The engagement and passion that this membership brings to the issues surrounding cancer care is truly energizing and gratifying. For that, I thank you all. I am also grateful for the leadership and engagement of our board of trustees and executive committee, who generously give their time in support of ACCC. I would be remiss if I did not thank incredibly dedicated and professional staff of the ACCC, who provide superlative support to the elected officers and trustees of the organization and to the membership at large. They truly make it the effective association that it is, and they are the heart and soul of ACCC.

I do not have a crystal ball, so I do not know exactly what cancer care will look like in the years to come. What I do know is that together we are stronger, smarter, and more resilient. ACCC will continue to be a platform for collaboration that helps us all to envision a future that will create value for and improve the lives of our patients. Thank you, and I look forward to seeing what comes in the next year. 

Coming in Your 2018 ONCOLOGY ISSUES

- ▶ One Community Cancer Center Shares Skin Cancer Prevention Initiatives for the Whole Family
- ▶ Leveraging Online Learning Opportunities and Videos to Improve Patient Education
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- ▶ A Comprehensive, Lifelong Management Program for Hereditary and Other High-Risk Patients
- ▶ Wheels Up: Bringing Lung Cancer Education and Screening to Rural Patients
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- ▶ Improving the Care of Pediatric Radiation Oncology Patients
- ▶ Expanding Our Reach: How Our Neuro-oncology Team Provides Next-Gen Cancer Care

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2017 Trending Now in Cancer Care

SURVEY This joint ACCC and Advisory Board Oncology Roundtable survey finds the cost of drugs and new treatment modalities as the top threat to cancer program growth, followed by physician alignment around services and programs and changes in healthcare coverage. Survey findings reveal that marketplace competition and consolidation continues. Staffing challenges are common. More than half report FTE vacancies for oncology nurses; nearly half have medical oncologist vacancies; 1 in 3 have openings for advanced practitioners. Read more at: accc.cancer.org/TrendingNow.



Are Your Patients Curious about CAR-T?

WEBINAR CAR-T therapy continues to make headlines. ASCO's Clinical Cancer Advances names this new type of immunotherapy the advance of the year. For an overview on this exciting treatment, view ACCC's archived webinar, CAR-T Therapy for Your Patients—What You Need to Know. accc-iclio.org/resources/car-t-cell-therapy-patients-need-know.



Immuno-Oncology Transforming Care Delivery

PUBLICATION This new report from ACCC explores the impact of immunotherapies on the cancer care paradigm. Read about effective practices in care delivery, managing immune-related adverse events, and why cross-discipline education is essential. Explore immunotherapy resources from ACCC, and more. accc-cancer.org/IO-TransformingCare.



Managing Immune-Related Adverse Events

ARTICLE Early recognition and management of immune-related adverse events (irAEs) is critical to optimizing patient care. Three cancer programs share details of the irAE management programs, including brief case studies. accc-cancer.org/IRAEmanagement.



ACCC's Website is Here!

RESOURCE In February ACCC launched its new website. Access the latest ACCC "how to" resources on your phone, tablet, laptop, or desktop. Connect with news, information, and your colleagues. Find information and resources curated for your role in cancer care. Explore accc-cancer.org.

fast



A new analysis of two clinical trials in the United States and Europe found that prostate-specific antigen (PSA) screening lowered the risk for prostate cancer death by 25 to 32 percent in men when compared with those who were not screened.

Source. Tsodikov A, et al. Reconciling the effects of screening on prostate cancer mortality in the ERSPC and PLCO trials. *Ann Intern Med*. Epub ahead of print 5 September 2017. doi: 10.7326/M16-2586.

Oncologists' Views on Emerging Therapies

- Most oncologists (**51%**) see CAR T-cell therapy as a game-changing approach to cancer treatment, but barriers such as cost, toxicity, and complex administration could lead to slow uptake.
- As more biosimilars enter the U.S. market, oncologists are open to prescribing them in place of their reference products—and most (**66%**) have high expectations about the cost savings biosimilars will deliver for their practices.
- With three targeted therapies recently approved for acute myeloid leukemia (AML), most oncologists (**85%**) are routinely prescribing genetic tests for AML patients—and **31%** are now referring AML patients to academic medical centers for treatment.

Source. Cardinal Health Specialty Solutions. cardinalhealth.com.



facts



Do Cancer Patients Want Genetic Testing?

- **62%** of respondents in one survey noted that if they developed cancer, they would want their cancer genetically tested to find other new treatments.
- Only **4%** would not want their cancer genetically tested.
- **23%** may want it.
- **11%** were unsure.

Source: Wamberg Genomic Consumer Survey. wamberggenomic.com.

How Americans Feel About the State of Healthcare in U.S.

- **41%** believe healthcare in the U.S. has generally gotten worse rather than improved over the past five years.
- While a vast majority of insured respondents (**83%**) say they are somewhat or very satisfied with their health plans, nearly **1/3** report that they did not have a choice in the health plan that was offered to them.
- **52%** of American parents are optimistic that their children will have better healthcare than they did at their age.
- **65%** say advances in healthcare will make lives safer; **66%** say advances will make lives longer.

Source: CVS Health. cvshealth.com/stateofhealthcare.

More Patients Asking Their Docs About Drugs in Ads



With drugmakers spending more than **\$5 billion** annually on direct-to-consumer (DTC) advertising, here's what physicians said in one survey:

- Compared to 5 years ago, where physicians reported receiving **1** question a week related to DTC advertising, physicians now report receiving **3** questions a week.
- When asked if their patients generally understand the information in advertisements, **65%** of physicians said no.
- **49%** percent of physicians said DTC ads generally impair or confuse their patients' understanding of their condition, the treatment, and possible risks.
- **35%** of physician respondents suggested banning DTC ads.

Source: InCrowd.incrowdnow.com/press-release/us-doctors-say-direct-consumer-ads-shaping-informed-patient-voicing-concerns-3x-many-questions-according-new-data-incrowd.

Study of More than 2,000 Women with Breast Cancer Finds...

- **93%** prefer that their oncologist handle their mammograms.
- **91%** want their oncologist to do screening for additional cancers.
- **21%** prefer that their oncologist direct general preventive care, such as vaccinations.
- **16%** want their oncologist to handle medical conditions unrelated to their cancer.

Source: Wallner LP, et al. Patient preferences for primary care provider roles in breast cancer survivorship care. *J Clin Oncol*. 2017 Jul 12. doi:10.1200/JCO.2017.



Another Wild Ride?

BY LEAH RALPH



Congress rang in the New Year with a massive tax overhaul and a government shutdown over immigration—another unpredictable year in Washington, D.C., seems like a foregone conclusion.

Now several months into 2018, is the turbulence slowing down or ratcheting up? Although MedPAC's January vote recommended that Congress eliminate the Merit-Based Incentive Payment System, the Department of Health and Human Services continues its push to tie Medicare reimbursement to quality and value with the new Quality Payment Program (QPP). Though CMS's 2018 regulatory updates to the QPP granted additional flexibility for clinicians (i.e., more exemptions and allowing providers to report in virtual groups), the agency also moved up the timeline for clinicians to be held accountable for the cost of care they provide their patients. An ACCC priority for 2018 is continuing ongoing advocacy efforts urging that QPP implementation be appropriately flexible and financially workable for clinicians.

Then, at the end of January, we saw Alex Azar sworn in as Department of Health and Human Services secretary. Unlike his predecessor, Tom Price, Secretary Azar is not a clinician, and it is likely that we will see less of a commitment to flexibility and reduced administrative burden for providers. Secretary Azar has indicated that he is not opposed to mandatory demonstration

programs, and we may see more of these from the Center for Medicare and Medicaid Innovation to advance the administration's goals. Secretary Azar's background in the pharmaceutical industry has also fueled speculation that the administration's proclaimed commitment to drug pricing reform—the details of which have been hazy at best—may gain some traction. During his confirmation hearings before the House Energy and Commerce Committee, Azar noted that drug prices are “too high.” Though opposed to government negotiation of drug pricing, Secretary Azar has indicated that he is not against some form of third-party negotiation in Medicare Part B (similar to pharmacy benefit managers in Medicare Part D). Whether Part B reimbursement will be in the spotlight again in the coming months is not clear but, as always, it is wise to buckle your seatbelt.

On the heels of CMS finalizing the policy to reduce Part B drug payments for 340B hospitals by nearly 30 percent in 2018, we are likely to see the debate around the 340B Drug Pricing Program heat up. The House Energy and Commerce Committee released a report calling for more transparency and reporting from providers and for Congress to give the Health Resources and Services Administration (HRSA) the authority and resources it needs to oversee the program. Meanwhile, two different bills have been introduced—one in the House and one in the Senate—that would place a moratorium on new entities entering the 340B program,

establish new reporting requirements for current 340B providers including drug acquisition costs and revenue, and require that HRSA promulgate new regulations that clarify the program. Last September, ACCC released principles for 340B reform that also call for more clarity from HRSA to better refine and sustain the program. Meanwhile, the American Hospital Association, the Association of American Medical Colleges, and America's Essential Hospitals are pursuing their lawsuit to prevent CMS from enforcing the reductions to 340B hospitals in 2018.

Where does the Affordable Care Act stand in the 2018 policy landscape? At the end of 2017, Congress repealed the individual mandate. Because this will almost certainly drive up premiums on the exchanges in 2019, some sort of market stabilization legislation will be imperative this year. Though some members of Congress seem committed to continuing efforts to repeal the Affordable Care Act, others, including Senate Majority Leader Mitch McConnell, are intent on “moving on” to other issues such as immigration and entitlement reform.

As the 2018 policy ride continues, the ACCC policy team is your GPS. Contact us with your questions and concerns as we navigate the road ahead together.

Leah Ralph is ACCC Director of Health Policy. 

compliance

Outpatient Department or Freestanding Center?

BY CINDY PARMAN, CPC, CPC-H, RCC

The United States' healthcare structure is unique among advanced industrialized countries. The United States lacks a uniform system and only recently enacted legislation mandating healthcare coverage for nearly everyone. In 2014, the federal government accounted for 28 percent of healthcare spending, whereas state and local governments accounted for 17 percent.¹

President Obama's Fiscal Year 2016 Centers for Medicare & Medicaid Services (CMS) budget submission to Congress included a proposal to equalize site-of-service payment between hospital outpatient department and physicians' offices. The proposal called for a four-year phase-in period. The projected savings were estimated to be \$29.5 billion over 10 years.

Provider-Based Departments

Before enactment of the Affordable Care Act, hospitals began to purchase physician practices and, by converting these locations to outpatient hospital departments, were able to bill for both the professional fee on the CMS1500 claim form and the facility charges on the UB04 claim form. This meant that hospitals were able to receive the higher Medicare payment by changing the practice setting from physician office to hospital outpatient department. The definitions of hospital departments are listed in Transmittal 57, dated Jan. 29, 2010:²

Definitions related to provider-based status are found at 42 CFR 413.65(a):²

Campus: Means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are

not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

Department of a provider: Means a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program and the personnel and equipment needed to deliver the services at that facility. A department of a provider may not itself be qualified to participate in Medicare as a provider under §489.2 of this chapter, and the Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term "department of a provider" does not include an RHC [Rural Health Center] or, except as specified in paragraph (n) of this section, an FQHC [Federally Qualified Health Center].

Remote location of a hospital: Means a facility or organization that is either created by, or acquired by, a hospital that is the main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital comprises both the specific physical facility that serves as the site

of services for which separate payment could be claimed under the Medicare or Medicaid program and the personnel and equipment needed to deliver the services at that facility. The Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term "remote location of a hospital" does not include a satellite facility as defined in §412.22(h)(1) and §412.25(e)(1) of this chapter.

Provider-based entity: Means a provider of health care services, or an RHC as defined in §405.2401(b) of this chapter, that is either created or acquired by the main provider for the purpose of furnishing health care services of a different type from those of the main provider under which the ownership and administrative and financial control of the main provider, in accordance with the provisions of this section. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program and the personnel and equipment needed to deliver the services at the facility. A provider-based entity may, by itself, be qualified to participate as a provider under §489.2, and the Medicare conditions of participation do apply to a provider-based entity as an independent entity.

Provider-based status: Means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or a satellite facility that complies with the provisions of this section.

Hospital providers are required to include all practice locations on the CMS 855A enrollment form. CMS also completed a revalidation process (from March 25, 2011, to March 23, 2015) to ensure that all hospital service facility locations were correctly listed.

Reimbursement for Off-Campus Provider-Based Departments

There are two current classifications for outpatient provider-based departments: excepted and nonexcepted (see Table 1, page 9). On Nov. 1, 2016, the CMS issued the Outpatient Prospective Payment System (OPPS) final rule for calendar year (CY) 2017. The summary for this final rule includes the following:³

Site-Neutral Payments Provision (“Section 603”):

CMS is implementing Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74) in the final rule with comment period and is establishing interim final payment rates under the Medicare Physician Fee Schedule (MPFS) in an IFC [Interim Final Rule with Comment Period] described in more detail below. As required by the statute, the final rule with comment period provides that certain items and services furnished by certain off-campus PBDs [Provider-Based Departments] shall not be considered covered outpatient department services for purposes of OPPS payment and shall instead be paid “under the applicable payment system” beginning January 1, 2017. CMS is finalizing several policies relating to which off-campus PBDs and which items and services are “excepted” from application of the payment changes under this provision and thus will continue to be paid under the OPPS.

Excepted Items and Services:

CMS is finalizing its proposals that certain off-campus PBDs would be permitted to continue to bill for excepted items and services under the OPPS. Excepted items and services are items and services furnished after Jan. 1, 2017:

- *By a dedicated emergency department;*
- *By an off-campus PBD that was billing for covered OPD services furnished prior to Nov. 2, 2015 (i.e., the date of enactment of Section 603 of the Bipartisan Budget Act of*

2015) that has not impermissibly relocated or changed ownership; or

- *In a PBD that is “on the campus,” or within 250 yards, of the hospital or a remote location of the hospital.*

Section 603 of the Balanced Budget Act is specific to any provider-based off-campus departments that were not billed as hospital departments as of Nov. 2, 2015. As a result, CMS established site-specific rates under the MPFS for the technical component of these “new” outpatient departments, which requires the application of an Healthcare Common Procedure Coding System (HCPCS) modifier. For CY 2018, the payment rate for these services will generally be 40 percent of the OPPS rate (with some limited exceptions). Packaging and certain other OPPS policies will continue to apply to such services.

In addition, CMS provided information on outpatient hospital service expansions, relocations, and changes of ownership.

Billing Off-Campus Provider-Based Departments

According to CMS, research literature and popular press have documented the increased trend toward hospital acquisition of physician practices, integration of those practices as a department of the hospital, and the resulting increase in the delivery of physician services in a hospital setting. When a Medicare beneficiary receives outpatient services in a hospital, the total payment amount for outpatient services made by Medicare is generally higher than the total payment amount made by Medicare when a physician furnishes those same services in a freestanding clinic or in a physician’s office.

To identify—and correctly reimburse—off-campus provider-based outpatient departments, CMS has created two HCPCS Level II modifiers. One modifier identifies those departments that meet the criteria for full OPPS reimbursement, and the other modifier identifies those departments subject to section 603 of the Balanced Budget Act of 2015 that will receive a reduction from the full OPPS payment.

In the CY 2015 OPPS Final Rule, CMS created an HCPCS modifier for hospital

claims that was to be reported with every code for outpatient hospital items and services furnished in an off-campus PBD of a hospital:

- **PO:** Excepted service provided at an off-campus, outpatient, provider-based department of a hospital.

Reporting of this modifier was voluntary for CY 2015 and became mandatory on Jan. 1, 2016. Of note, the modifier does not apply to critical access hospitals (CAHs) because CAHs are not paid through the OPPS.

CMS also publishes a list of frequently asked questions regarding modifier PO, which includes the following:⁴

Q: *Should the PO modifier be applied for drugs or laboratory services?*

A: *The determinative factor is whether or not the item or service is being paid through the OPPS. If an item or service is being provided by an applicable provider and is being paid through the OPPS, then the PO modifier should be applied.*

For instance, a drug with an OPPS status indicator of “K” or a laboratory test that is packaged into an OPPS service should have the PO modifier applied. If a service is not paid through the OPPS, such as a laboratory test paid separately through the Clinical Laboratory Fee Schedule, it should not have the PO modifier applied.

Note that the Medicare Claims Processing Manual Chapter 4 20.6.11 was updated in July 2015 to read: “This modifier is to be reported with every HCPCS code for all outpatient hospital items and services furnished in an off-campus provider-based department a hospital.”

As the modifier PO definition states, this modifier is only reported for “excepted” services, such as those services paid in full under the OPPS. With respect to non-excepted items and services, MLN Matters MM9930 provides the following:⁵

In accordance with the Social Security Act (Section 1833(t)(21)), as added by Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS has established a new modifier, “PN” (non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital), to identify and pay non-excepted items and services billed on an

Table 1. Current Classifications for Outpatient Provider-Based Departments

Excepted	<p>An off-campus outpatient provider-based department billing for covered services prior to Nov. 2, 2015</p> <p>Requires the application of an HCPCS modifier on codes for covered services</p> <p>A dedicated emergency department</p> <p>An on-campus provider-based department</p> <p>Reimbursed under the OPSS</p>
Nonexcepted	<p>An off-campus outpatient provider-based department billing as a hospital location after Nov. 2, 2015</p> <p>Requires the application of an HCPCS modifier on codes for covered services</p> <p>Reimbursed at 40 percent of the OPSS allowance (payment is actually made under the Medicare Physician Fee Schedule)</p>

reimbursed the same allowance regardless of whether the service is excepted or non-excepted.

Freestanding Centers Owned or Operated by Hospital

Though some facilities or practices are purchased by the hospital with the intent of becoming hospital departments, there are also situations where the hospital purchases an office or freestanding treatment center and continues to operate the facility as a physician office. These units are considered to be wholly owned or wholly operated by one or more hospitals but bill on the CMS1500 professional claim form.

An entity is considered to be “wholly owned or operated” by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility’s routine operations), regardless of whether or not it also has the authority to make the policies.

When freestanding entities are wholly owned or wholly operated by a hospital, technical services performed up to 3 days prior to patient admission to the hospital are included on the inpatient hospital bill. According to the *Medicare Claims Processing Manual*, chapter 4:⁷

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary’s admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

For outpatient nondiagnostic services furnished on or after June 25, 2010, all outpatient nondiagnostic services, other than

institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line for non-excepted items and services. The use of modifier “PN” will trigger a payment rate under the Medicare Physician Fee Schedule. CMS expects the PN modifier to be reported with each non-excepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

Excepted off-campus provider-based departments of a hospital must continue to report existing modifier “PO” (services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items and services furnished. Use of the off-campus provider-based department (PBD) modifier became mandatory beginning January 1, 2016.

CMS would not expect off-campus PBDs to report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a non-excepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the non-excepted claim lines.

The modifier is:

- **PN:** Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital.

Professional Billing in Off-Campus Provider-Based Departments

Professional billing reports one of the following place of service codes on the CMS1500 claim form, which differentiate between on-campus and off-campus departments:⁶

- **19: Off-Campus Outpatient Hospital:** A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **22: On-Campus Outpatient Hospital:** A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

There is no professional reimbursement differential for services reported on the CMS1500 claim form; the physician is

ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and thus must be billed with the inpatient stay.

Also, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the Inpatient Prospective Payment System (IPPS) (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission and thus must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51—Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Beginning on or after April 1, 2011, providers may submit outpatient claims with condition code 51 for outpatient claims that have a date of service on or after June 25, 2010.

The Medicare Claims Processing Manual, Chapter 12, adds:⁸

CMS has established HCPCS payment modifier PD (diagnostic or related nondiagnostic item or service provided in a wholly owned or operated physician office to a patient who is admitted as an inpatient within 3 days) and requires that the modifier be appended to the physician preadmission diagnostic and admission-related nondiagnostic services, reported with HCPCS/Current Procedural Terminology (CPT) codes, which are subject to the 3-day payment window policy.

The wholly owned or wholly operated physician's office will need to manage their billing processes to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. The hospital is responsible for notifying the practice of an inpatient admissions for a patient who received services in a wholly

owned or wholly operated physician office within the 3-day (or, when appropriate, 1-day) payment window prior to the inpatient stay. The modifier is effective for claims with dates of service on or after January 1, 2012. Entities have the discretion to apply these policies for claims with dates of service on and after January 1, 2012, but shall comply with these policies no later than July 1, 2012. When the modifier is present on claims for service CMS shall pay:

- Only the Professional Component (PC) for CPT/HCPCS codes with a Technical Component (TC)/PC split that are provided in the 3-day (or, in the case of non-IPPS hospitals, 1-day) payment window, and
- The facility rate for codes without a TC/PC split.

According to a related Frequently Asked Questions document published by CMS:⁹

Section 102 of Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) significantly broadened the definition of related nondiagnostic services that are subject to the payment window to include any non-diagnostic service that is clinically related to the reason for a patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same. PACMBPRA made no changes to application of the 3-day (or 1-day) payment window policy to diagnostic services. Application of the payment window policy to diagnostic services is unchanged since 1998.

The 3-day payment window applies to services provided on the date of admission and the 3 calendar days preceding the date of admission that will include the 72 hour time period that immediately precedes the time of admission but may be a longer than 72 hours because it is a calendar day policy.

The technical component for all diagnostic services and those direct expenses that otherwise would be paid through non-facility practice expense relative value units for nondiagnostic services related to the inpatient admission, provided by a wholly owned or wholly operated entity within the payment window, are considered hospital costs and must be included on the hospital's bill for the inpatient stay. Medicare will pay the wholly owned or wholly operated entity through the Physician Fee Schedule for the professional

component (PC) for service codes with a Technical/Professional Component (TC/PC) split that are provided within the payment window, and at the facility rate (i.e. exclusive of those direct practice expenses that are included in the hospital's charges) for service codes without a TC/PC split.

A wholly owned or wholly operated Ambulatory Surgical Center (ASC) would use the modifier PD to identify outpatient physician or practitioner services subject to the 3-day (or 1-day) payment window.

The modifier is:

- **PD:** Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days.

Summary

Medicare has different payment systems to pay for services provided on an outpatient basis. In summary:

- Medicare pays for physician professional services provided in a physician's office under the Medicare Physician Fee Schedule.
- If that same service is provided in a hospital setting, Medicare pays the professional component to the physician and also pays a facility fee under the hospital's OPSS.
- When Medicare pays an MPFS professional fee and an OPSS facility fee, the total payment is typically higher than if the service was provided and billed under the PFS only. As a result, section 603 of the Balanced Budget Act of 2015 implemented different payment systems, based on the nature of the outpatient facility.
- Excepted off-campus outpatient provider-based department services are reimbursed under the OPSS. The hospital reports modifier PO on each code billed on the UB04 claim form and the physician reports place of service 19 on the CMS1500 claim form.
- Nonexcepted off-campus outpatient provider-based services are generally reimbursed at 40 percent of the OPSS allowance for CY 2018. The hospital reports modifier PN on each code billed on the UB04 claim form and the physician

reports place of service 19 on the CMS1500 claim form.

- Freestanding centers or physician offices that are wholly owned or wholly operated by one or more hospitals must append modifier PD to services performed 1 to 3 days prior to patient admission in one of the owner hospitals. Medicare will only reimburse professional services during this 3-day period; the hospital should include the technical charges on the claim for inpatient services.

According to a MedPAC report to Congress on Medicare Payment Policy in May 2017, the goal of Medicare payment policy is to get good value for the program's expenditures.¹⁰ This means maintaining beneficiaries' access to high-quality services while encouraging the effective use of resources. The reimbursement challenges affecting hospital outpatient departments are one aspect of delivery system reforms that focus on high-quality care, better care transitions, and more efficient provision of care. **OI**

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spotlight

Providence Cancer Center Anchorage, Alaska



When your catchment area is twice the size of Texas, parts of your community are only accessible by boat or plane, and cancer patients sometimes delay treatment to go subsistence hunting, it takes a special group of professionals to form a cancer program able to adapt to extraordinary barriers to care. Providence Cancer Center in Anchorage, Alaska, is up to that task.

Located on the grounds of the Providence Health & Services campus in Anchorage, Providence Cancer Center is an outpatient clinic that occupies a three-story tower. The program offers state-of-the-art medical, radiation, and surgical oncology services, as well as a wide variety of supportive services. Most of the imaging services are performed at the main hospital connected to the main hospital campus by a walkway. The cancer center is staffed by 98 employees and has the state's only pediatric infusion and oncology centers, with subspecialists available for the treatment of pediatric patients.

Overcoming Barriers

Providence Cancer Center faces unique barriers to the delivery of cancer care. The northernmost tip of Alaska, Utqiagvik, is a two-hour plane ride away, as is the southernmost tip of the Alaska Panhandle. As a tertiary care provider, Providence Cancer Center is referred patients from the small critical access hospitals and clinics in these remote communities. Treatment and travel is often coordinated well in advance, in case patients' homes are inaccessible during flooding season or they must go hunting or

whaling for sustenance. Social workers who work at the cancer center are required to complete 6 hours of Alaska Native-specific cultural education every 2 years.

With these additional logistical concerns, patient navigation plays an even more crucial role in treatment than in most cancer programs and is available for all disease sites. Says Bethany Zimpelman, CPON, MSN, a pediatric oncology and infusion nurse, "I never imagined in nursing school that I would be spending time on the phone arranging Medicaid plane travel, or how patients would be getting on their boat from their island." Navigators are available to assist any person diagnosed with cancer—regardless of where they receive treatment.

One unique resource the cancer center provides patients coming from disparate locations is the Hickel House, a guest hotel funded by a family donation. Providence Cancer Center maintains the building, and though patients pay when they can, it is still available for patients and their family members if they cannot. Says Ella Goss, MSN, RN, director of the center, "At Providence we care for the poor and vulnerable no matter what, and our values are built around justice, stewardship, excellence, and compassion."

Providence Cancer Center has a strong partnership with the American Cancer Society, which provides resources to patients with barriers to access. A dedicated American Cancer Society navigator is colocated with the Providence Cancer Center navigators and partners with the cancer center team to coordinate funding for flights

and lodging, as well as referrals to Providence navigators for medical emergencies, psychosocial needs, and family dynamics support.

"We have such a huge geographic area to get patients in," says Betsy Baldwin, MSHA, manager of radiation oncology, "and, in general, the navigation department coordinates it very well."

Comprehensive Multidisciplinary Care

Providence Cancer Center's separation from the contiguous United States does not affect its quality of care. In fact, the cancer center has the same technology and works at the same capacity as some of the most prestigious academic programs in the lower 48. Prior to the hospital's colocation of the cancer center into a tower in 2008, the cancer center's infusion center was significantly smaller, and patients would often have to be sent to Washington for treatment. Now, the center has a 12-bed infusion center for adults and a seven-bed infusion center for pediatric patients, and patients rarely have to go outside the state.

The approach to care at Providence Cancer Center is multidisciplinary. All cancer patients are seen by a team including, as needed, medical oncology, radiation oncology, and surgical oncology. Radiation oncology reviews the treatment plans for every patient, and the gynecologic oncology group meets every week to review all patients under service as well. Pediatrics conducts interdisciplinary rounds once a week to review all of its patients, with a separate tumor board that includes other

disciplines. When necessary, genetic counseling is available over the phone for patients who must travel a significant distance to the cancer center. The cancer center also provides social work, child life therapy, and hospital-based schooling as needed.

The radiation oncology department offers comprehensive radiation therapy services, including TomoTherapy, CyberKnife, and TruBeam; the medical director of the program actively seeks out new technologies that provide the most benefit to the center's patients.

Providence Cancer Center has a number of accreditations that serve as proof of its high level of care. Through Providence Health & Services, the cancer program is accredited by The Joint Commission and the American College of Radiology. Providence Cancer Center is currently in the process of achieving American College of Surgeons Commission on Cancer accreditation as well.

The program provides a robust clinical trials program, with a total of 97 oncology trials running and 34 adult trials currently open to enrollment. Most trials are sponsored by the National Cancer Institute. Pediatric oncology also has 18 open clinical trials through the Children's Oncology Group; prior to their partnership with the Children's Oncology Group, pediatric patients had to travel out of state to participate in clinical trials.

In addition to its clinical services, Providence Cancer Center offers a vast array of supportive care services, including the following:


- A dedicated chaplain
- A support center for the children of cancer patients
- A dietitian who provides cookbooks and consultations to anyone in need
- A resource center in the lobby with a library of oncology education materials on the center's services.

An oncology rehabilitation team located within the cancer center hosts group training programs and also works one on one with patients, in addition to providing treatment for lymphedema. The rehab team also partners with the hospital's outpatient speech therapy department on swallow

safety screens for head-and-neck cancer patients.

Beyond Patient-Centered Care

The resources in the Women's Boutique are emblematic of the patient-centered approach that Providence Cancer Center takes in its care. When there were not adequate resources available in Anchorage to meet the needs of women with cancer, the cancer center decided to create its own. The boutique is stocked with complimentary items intended to ease the side effects of breast cancer treatment, including drainage belts, postsurgical camisoles, comfort pillows, prostheses, lymphedema garments, and seat belt loops. The entire navigation team has training in wig-fitting, and a breast cancer navigator works specifically with breast cancer patients. The boutique is staffed by volunteers, and cancer-related products are provided through grants from the American Cancer Society and the Providence Foundation without concern for the patient's financial need. Says Sara Cockerham, LCSW, OSW-C, manager of cancer resources and patient navigation, "The purpose of the space itself is to respect the dignity of the individual who has a need and provide the type of one-on-one care and support that can bring about significant emotional connection between our patients and staff."

"We're proud to provide amazing care to patients," says Goss. "We do it with excellence and cutting-edge technology, and we have fantastic people who choose to be caregivers in our community." 



Select Support Services

- Spiritual care
- Genetic counseling
- Nutrition services
- Women's boutique
- Patient navigation

Number of new analytic cases seen in 2017: 1100 (41 pediatric cases)

tools



Approved Drugs

- The U.S. Food and Drug Administration (FDA) has granted approval to **Cabometyx® (cabozantinib)** (Exelixis, Inc., exelixis.com) for the treatment of patients with advanced renal cell carcinoma.
- Boehringer Ingelheim Pharmaceuticals, Inc. (boehringer-ingelheim.com) has announced that the FDA has granted approval to **Gilotrif® (afatinib)** for a broadened indication in first-line treatment of patients with metastatic non-small cell lung cancer whose tumors have nonresistant epidermal growth factor receptor mutations as detected by an FDA-approved test.
- The FDA has approved Advanced Accelerator Applications' (adacap.com) **Lutathera® (lutetium Lu 177 dotatate)** for the treatment of gastroenteropancreatic neuroendocrine tumors. Lutathera is indicated for adult patients with somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors.
- AstraZeneca Pharmaceuticals (astrazeneca.com) has announced that the FDA has expanded the approved use of **Lynparza® (olaparib tablets)** to include the treatment of patients with certain types of breast cancer that have metastasized and whose tumors have a specific inherited (germline) genetic mutation. Patients are selected for treatment with Lynparza based on an FDA-approved genetic test called the BRACAnalysis CDx.
- The FDA has approved **Ogivri™ (trastuzumab-dkst)** (Mylan GmbH, mylan.com) as a biosimilar to Herceptin® (trastuzumab) for the treatment of patients with breast or metastatic stomach cancer (gastric or gastroesophageal junction adenocarcinoma) whose tumors overexpress the HER2 gene (HER2+).
- Bristol-Myers Squibb Company (bms.com) announced that the FDA has approved **Opdivo® (nivolumab)** injection for intravenous use for the adjuvant treatment of patients with melanoma with involvement of lymph nodes or metastatic disease who have undergone complete resection.
- The FDA has approved the use of Teva Pharmaceutical Industries' (tevapharm.com) **Trisenox® (arsenic trioxide)** injection in combination with tretinoin for the treatment of adults with newly diagnosed low-risk acute promyelocytic leukemia whose acute promyelocytic leukemia is characterized by the presence of the t(15;17) translocation or PML/RAR-alpha gene expression.
- Agios Pharmaceuticals, Inc. (agios.com) has announced that it has submitted a new drug application to the FDA for **AG-120 (ivosidenib)**, an investigational oral treatment for patients with relapsed or refractory acute myeloid leukemia and an isocitrate dehydrogenase-1 mutation.
- Merck and Co., Inc. (merck.com) and Pfizer, Inc. (pfizer.com) announced that the FDA has granted breakthrough therapy designation for **Bavencio® (avelumab) in combination with Inlyta® (axitinib)** for treatment-naïve patients with advanced renal cell carcinoma.
- The FDA has cleared BioAtla's (bioatla.com) investigational new drug application for **BA3011**, a novel conditionally active AXL-targeted antibody-drug conjugate (CAB-AXL-ADC) in patients with solid tumors. Under this investigational new drug application, the company intends to initiate a first-in-human, open label, multicenter dose escalation and dose expansion study of CAB-AXL-ADC in patients with locally advanced or metastatic solid tumors.
- The FDA has approved a supplemental new drug application (sNDA) for Pfizer's ([Pfizer.com](http://pfizer.com)) **Bosulif® (bosutinib)**. The approved sNDA expands the indication for Bosulif to include the treatment of adult patients with newly diagnosed chronic phase Philadelphia chromosome-positive chronic myelogenous leukemia.

Drugs in the News

- Seattle Genetics, Inc. (seattlegenetics.com) announced that the FDA has accepted for filing a supplemental Biologics License Application (sBLA) for **Adcetris® (brentuximab vedotin)** in combination with chemotherapy for the frontline treatment of patients with advanced classical Hodgkin lymphoma.


- Aptose Biosciences Inc. (aptose.com) announced that the FDA has granted orphan drug designation to **CG'806**, a pan-FLT3/pan-BTK inhibitor, for the treatment of patients with acute myeloid leukemia.
- The FDA has granted fast track designation for Arog Pharmaceuticals' (arogpharma.com) **crenolanib** for the treatment of patients with FLT3 mutation-positive relapsed or refractory acute myeloid leukemia.
- Cantex Pharmaceuticals, Inc. (cantex.com) has announced that the FDA has granted orphan drug designation to **CX-01** for the treatment of acute myeloid leukemia. CX-01 is an investigational agent that has the potential to enhance the effectiveness of leukemia treatments by disrupting the adhesion of leukemia cells in the protective bone marrow environment.
- The FDA has granted priority review designation to **Darzalex® (daratumumab)** (Janssen Biotech, Inc., janssen.com) in combination with Velcade® (bortezomib), melphalan, and prednisone for the treatment of patients with newly diagnosed multiple myeloma who are ineligible for autologous stem cell transplant.
- Idera Pharmaceuticals, Inc. (iderapharma.com) has announced that the FDA has granted fast track designation for the company's **IMO-2125 in combination with ipilimumab** for the treatment of anti-PD-1 refractory metastatic melanoma in combination with ipilimumab therapy.
- The FDA granted breakthrough therapy designation to Novartis (novartis.com) for **Kisqali® (ribociclib)**, an initial endocrine-based treatment of pre- or perimenopausal women with hormone receptor-positive, human epidermal growth factor receptor-2-negative (HR+/HER2-) advanced or metastatic breast cancer in combination with tamoxifen or an aromatase inhibitor.
- Novartis (novartis.com) announced that its sBLA for **Kymriah™ (tisagenlecleucel)** suspension for intravenous infusion, formerly CTL019, for the treatment of adult patients with relapsed or refractory (r/r) diffuse large B-cell lymphoma who are ineligible for or relapse after autologous stem cell transplant has been accepted by the FDA for priority review.
- The FDA has approved Amgen's (amgen.com) sNDA to add overall survival data from the Phase II head-to-head ENDEAVOR trial to the Prescribing Information for **Kyprolis® (carfilzomib)**.
- Eisai Co., Ltd. (eisai.com) and Merck (merck.com) have announced that they received FDA breakthrough therapy designation for **Lenvima® (lenvatinib) in combination with Keytruda® (pembrolizumab)** for the potential treatment of patients with advanced and/or metastatic renal cell carcinoma.
- The FDA has updated the product label for **Tasigna® (nilotinib)** (Novartis Pharmaceuticals Corporation, novartis.com) to include information for providers about how to discontinue the drug in certain patients.
- Amgen (amgen.com) has announced that the FDA has approved the sBLA for **Xgeva® (denosumab)** to expand the currently approved indication for the prevention of skeletal-related events in patients with bone metastases from solid tumors to include patients with multiple myeloma.

Approved Devices

- The FDA has cleared the **GammaPod™ system** (Xcision Medical Systems, LLC, xcision.com) for use in the noninvasive stereotactic delivery of a radiation dose to a portion of the breast in conjunction with breast conserving treatment.
- Bracco Diagnostics Inc. (imaging.bracco.com) announced that the labeling of its contrast agent **MultiHance®** has obtained FDA approval for an extension to include magnetic resonance imaging of

the central nervous system in pediatric patients younger than 2 years of age to visualize lesions with an abnormal blood-brain barrier or abnormal vascularity of the brain, spine, and associated tissues.

Genetic Tests and Assays in the News

- Myriad Genetics, Inc. (myriad.com) announced that the FDA has approved **BRACAnalysis CDx®** for use as a companion diagnostic by healthcare professionals to identify patients with HER2-negative metastatic breast cancer who have a germline BRCA mutation and are candidates for treatment with the PARP inhibitor Lynparza (olaparib).
- The FDA has approved **FoundationOne CDx™ (F1CDx)** (Foundation Medicine, Inc., foundationmedicine.com), a next-generation sequencing-based *in vitro* diagnostic test that can detect genetic mutations in 324 genes and two genomic signatures in any solid tumor type. The Centers for Medicare & Medicaid Services (CMS) at the same time proposed coverage of the F1CDx.
- Sebia (sebia.com) has announced that it has received FDA 510(k) clearance for its **Hydrashift 2/4 daratumumab assay**, intended to be used with Hydragel IF, for the qualitative detection of monoclonal proteins in human serum by immunofixation electrophoresis. 

CMS Proposes Coverage for the Oncomine Dx Target Test

The CMS has proposed coverage for the Oncomine Dx Target Test (Thermo Fisher Scientific, thermofisher.com) as part of a national coverage determination for next-generation sequencing *in vitro* diagnostic tests. Once implemented, the national coverage determination would provide Medicare beneficiaries with reimbursable testing using Thermo Fisher Scientific's multi-biomarker non-small cell lung cancer diagnostic.





Developing an Acuity Tool to Optimize Nurse Navigation Caseloads

On July 1, 2016, the University of South Alabama Mitchell Cancer Institute, along with the 189 selected oncology practices and 14 commercial payer groups, committed to practice transformation through participation in the Center for Medicare and Medicaid Innovation’s oncology care model (OCM). The OCM is the Centers for Medicare & Medicaid Services’ first new payment and delivery model in oncology. Also known as an alternative payment model, the OCM was developed to provide practices and payers an avenue to transform the care of oncology patients, by requiring higher quality care and enhanced services, while focusing on efficiency, effectiveness, and cost savings. According to CMS, the “OCM encourages participating practices to improve care and lower costs through an episode-based payment model that financially incentivizes high-quality, coordinated care.”¹ Ultimately, the OCM strives for all participants to meet the three goals set forth for the model: better care, smarter spending, and healthier people.¹

Implementing an OCM Task Force

A hallmark of OCM participation is the list of program requirements that each practice must fulfill to remain in the model. From

Also known as an alternative payment model, the OCM was developed to provide practices and payers an avenue to transform the care of oncology patients, by requiring higher quality care and enhanced services, while focusing on efficiency, effectiveness, and cost savings.

the start of the OCM, it was evident that one individual—or even several staff working together—would not be able to carry the burden of accomplishing the OCM requirements alone. As Mitchell Cancer Institute quickly realized, successful program transformation and eventual shared savings would require the efforts



University of South Alabama Mitchell Cancer Institute, Mobile, Ala.

enhanced oncology services (MEOS) payment, billable monthly for each patient on a 6-month episode in the model, the MEOS payments would not be enough to cover expansion of the program. The reality is that nurse navigation services are costly and are generally not reimbursable. To sustain and expand a nurse navigation program long term without relying on short-term funding from outside sources, the Task Force recognized that Mitchell Cancer Institute must be able to optimize the use of available resources and quantify the value of its nurse navigation program through standardization and metrics data collection.

Growing Need for Oncology Nurse Navigators

As the complexity of cancer care delivery has increased with each new therapy and treatment approved to market, the need for oncology nurse navigators has grown exponentially. The “silver tsunami,” also known as the quickly aging Baby Boomer population, will soon inundate the healthcare system. An estimated 72.1 million patients will be age 64 or older by 2030. Predictions of 26.1 million cancer survivors by 2040³ speak to the advancement and efficacy of today’s cancer therapies; though this is very good news, these numbers promise to challenge already strained healthcare systems, especially those providing oncology care services.⁴

As research advances bring rising numbers of new treatment modalities, chemotherapeutic agents, immunological agents, and combination therapies, the majority of these newer anticancer drugs are oral agents. Although oral therapies can be taken at home, potentially eliminating the need to travel long distances to a physician’s office or infusion suite, many of the oral oncolytics potentially have significant side effects that require patient monitoring at the same or higher level as intravenous therapies. For this reason, most of the oral agents have special requirements, such as regular laboratory testing and the need to be taken on a specific schedule. With the absence of constant monitoring of drug administration by healthcare professionals, patients may easily feel overwhelmed or underestimate the side effects of oral cancer therapies, ultimately leading to increased stress, the potential for incorrect medication administration, noncompliance, and/or a delay in recognizing and seeking treatment of serious side effects. The issues surrounding the oral therapies create a laborious and burdensome challenge for healthcare professionals given that the medication management is driven by the patient.

Under these circumstances, clinical nurse navigation programs are no longer optional luxuries afforded only by large institutions. Instead, these programs increasingly become the first—and sometimes only—navigation services implemented at cancer centers. To adequately coordinate the clinical care of a growing patient population, likely receiving multiple treatment modalities and medications while attempting to navigate a complex healthcare system, a clinically trained advocate with the experience and skills to anticipate needs, answer questions, and educate on diagnosis and/or treatment must be available to patients to guide them through their cancer journey. The nurse navigator is at the core of every patient’s care and is responsible for coordinating clinical care, referring to ancillary services, and fostering communication

of a team, with each member contributing his or her own talents and skills. This led to the formation of Mitchell Cancer Institute’s OCM Task Force. Composed of representatives from administration, finance, nursing, navigation, quality, pharmacy, clinical applications, cancer control, and clinical revenue integrity, Mitchell Cancer Institute’s OCM Task Force has guided our practice through the ever-evolving iterations of the OCM practice requirements. This team is responsible for ensuring that OCM program information and updates are relayed to and understood by both the OCM Task Force members and the practice. The OCM Task force also monitors and interprets the feedback report data from CMS and then brainstorms and implements transformational initiatives based on our site-specific data.

Before the start of the model, the OCM Task Force assessed Mitchell Cancer Institute’s readiness to fulfill OCM requirements and identified two requirements and one eligibility criterion that were anticipated to be difficult to implement:

1. The OCM program requirement to provide the core functions of patient navigation.
2. The OCM program requirement to create a care plan that contains the 13 components in the Institute of Medicine’s care management plan.²
3. The complex OCM oral therapy eligibility criteria and the level of difficulty involved in obtaining the data necessary to determine patient eligibility (i.e., prescription fill dates).

Although Mitchell Cancer Institute had previously established lay and financial navigation services, to provide the more comprehensive navigation services required by the OCM, the Task Force determined that the addition of a clinical component, or nurse navigation program, would be necessary to fulfill unmet clinical needs. As a result, shortly after the start of the OCM, Mitchell Cancer Institute hired two extensively trained oncology nurse navigators and a navigation manager to provide program oversight and clinical support.

Although the initial cost of Mitchell Cancer Institute’s nurse navigation program was covered by the OCM’s \$160 monthly

across the continuum. Although navigation services are not currently reimbursable outside of special programs and/or grant funding, most cancer centers have realized that the true value of adding nurse navigators to the oncology care team is manifested through the following:

- Reduction of clinical barriers to care.
- Increased access to care.
- Earlier identification and treatment of symptoms and side effects.
- Reduction of both emergency room (ER) visits and hospital admissions.

This realization signifies the commitment of these practices to quality-based patient care and further proves that the practice understands that the up-front investment in a nurse navigation program will reap far greater benefits down the road (in terms of both monetary and clinical outcomes measures) than the initial investment costs.

Survival in the Age of Value-Based Care

For OCM participants committed to practice transformation but needing funding (more than MEOS payments can provide) to support ongoing activities and program implementations, nurse navigation presents a difficult quandary. Most practices agree that nurse navigators add value to the healthcare team, but the addition of highly qualified oncology nurse navigators will most likely have an initial significant impact on the bottom line. Nurse navigation programmatic labor costs are high and, under most circumstances, these services are not reimbursable. The challenge is twofold. First, how do we quantify the value of navigation services, proving increased savings and eventual downstream revenue to both the inpatient and the outpatient settings? Second, how do we optimize utilization, workflow, and program management of current nurse navigation staff to obtain buy-in and support for adding additional FTE nurse navigators?

Historically, practices have struggled with quantifying the value of navigation services compared to the initial cost. Although nurse navigation-specific feedback from both healthcare teams and patients has been positive, few validated tools and/or measures are available to evaluate whether navigation services impact the quality or the value of the oncology care delivered. Without a nationally recognized set of nurse navigation metrics, each practice has independently determined its own set of metrics based on unique program needs and, not surprisingly, some practices have not yet determined a way to collect or measure nurse navigation-specific outcomes.

In 2016 the Academy of Oncology Nurse & Patient Navigators (AONN+) announced the development of 35 evidence-based national navigation metrics that focused on the AOWeNN+ certification domains for navigation. The metrics included measures in the areas of patient experience, clinical outcomes, and business performance and return on investment. These proposed evidence-based metrics will allow practices to collectively demonstrate both the impact and value of navigation services (both lay and clinical), thus reinforcing the need for navigation services

and securing the program's role within the oncology care team. AONN+ proposed to develop a standardized metrics repository, allowing practices to easily report site-specific outcomes and potentially share data nationally. Historically missing from most nurse navigation workflows, this data collection, reporting, and analysis is a critical step that demonstrates the validity of navigation services for the practice decision makers.⁵

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Even with standardized metrics used across multiple sites, nurse navigation services are generally still limited to higher acuity patient populations, tumor sites, insurance groups, job duties, or other demographics, due to high labor costs and/or lack of qualified applicants to fill open positions. This limitation frequently results in larger caseloads, limited services, and less time available to document the much-needed quality metric data necessary for program validation.

Nurse and Lay Navigators Working in Concert

Lay navigation, a coordinated system of care delivery utilizing non-clinically trained professionals, was developed by Harold P. Freeman, MD, and is often used as a solution to reducing disparities and barriers to accessing healthcare in underserved populations. Dr. Freeman first introduced the idea of lay navigation in 1990 at Harlem Hospital Center for underserved breast cancer patients.⁶ From 1995 to 2000, Dr. Freeman studied the utilization of his lay navigation program, noting a considerable improvement in early stage diagnosis and survival rates of breast cancer patients treated at Harlem Hospital Center.⁶ Since the idea of lay navigation was first introduced in 1990, these programs have existed as functioning components of the oncology healthcare team and can be found in many cancer centers worldwide, often as a supplement to nurse navigation programs.

Since then, lay navigators have proven to decrease barriers to care and reduce overall costs. In 2012, Mitchell Cancer Institute opted to implement a lay navigation program through participation in the University of Alabama at Birmingham Patient Care Connect Program. The Patient Care Connect Program, including two academic medical centers and 10 community cancer centers across the southeastern United States, was an observational study of 12,428 patients conducted from 2012 to 2015. Its goal was



Mitchell Cancer Institute Quality and Navigation Nurses (L to R): Troy Bland, Diane Baldwin, Mary Wyatt, Meredith Jones.

“to deploy a workforce of lay navigators who will provide patients with information about the process of cancer treatment, help patients make informed choices about their care, provide emotional and problem-solving support, assist with overcoming common barriers to cancer treatment, and encourage patients to make wise use of healthcare resources.”⁷ The Patient Care Connect Program successfully demonstrated a reduction in mean total costs, emergency room visits, hospitalizations, and intensive care unit admissions across the participating sites.⁸

The addition of lay navigators to existing nurse navigation teams, with intent to offload much of the nonclinical functions from nurse navigators, and address the crucial—and sometimes more burdensome—nonclinical gaps of care often overlooked by clinical providers. Integration of lay navigation services aimed to provide holistic care for patients’ broad spectrum of needs. Unlike others in the Patient Care Connect Program, Mitchell Cancer Institute lacked a clinical nurse navigation program during that time. Therefore, Mitchell Cancer Institute participated in the Patient Care Connect Program primarily to determine whether a less-expensive lay navigation program could equate to the more expensive nurse navigation program, while successfully addressing the majority of patient needs in a cost-effective, budget-friendly manner. Contrary to the overall Patient Care Connect Program data for all sites, Mitchell Cancer Institute site-specific data indicated that the 4-year study averages of overall mean costs, hospitalizations, ER visits, and intensive care unit admissions were higher for lay navigated patients when compared to non-navigated patients. A suspected reason for these outcomes was that the metrics being measured were clinical. Logically, without a complementary clinical nurse navigation program, the lay navigation program would not have much effect on clinical metrics, such as ER visits and hospitalizations, or phases of care, such as diagnosis and treatment, that require clinical intervention and symptom management. Therefore, the data supported the

need for a nurse navigation program at Mitchell Cancer Institute to:

- Work in collaboration with lay navigators
- Support providers, staff, and patients
- Ensure that patients’ needs were being met clinically and psychosocially throughout the continuum of care.

Today, as part of the OCM practice transformation initiative, Mitchell Cancer Institute’s navigation program includes both nurse and lay navigators. The lay navigators support patients by removing barriers to care, assistance with transportation services, spiritual services, financial needs, and related nonclinical services. They also provide education and support on advance care planning, community resources, and support groups. This collaboration allows our nurse navigators to focus solely on clinical issues (i.e., diagnosis, treatment plans, chemotherapy, symptom management, oral oncolytic management), whereas our lay navigators provide nonclinical social support. Together they work collaboratively in delivering a multidisciplinary, holistic, and comprehensive cancer care experience for patients.

Nurse Navigation Caseload Management

Although Mitchell Cancer Institute’s nurse navigators have a narrow focus, they maintain a caseload of between 175 to 225 patients each, with new patients requiring nurse navigation services every day. The average patient requires nurse navigation for 6 to 12 months. To ensure manageable caseloads and justify the need for future expansion of nurse navigation services, we must use risk stratification to define appropriate caseload volumes and determine how best to allocate nurse navigation time and resources among those existing caseloads. The ability to risk stratify patients requires (1) a standardized method of classifying patients according to a set of predetermined criteria and (2) assessment of all patients according to the chosen method. Acuity tools have been used in healthcare for decades. They provide a simple way to risk stratify patients and have proven successful as a means of determining staffing needs, improving patient care, and controlling costs. Most existing acuity tools score patients on a scale of specific attributes. For nurse navigation programs, utilizing the right acuity tool can not only be useful in determining caseloads and aiding in more efficient caseload management, but it can harness the patient acuity data into a score that can be used for comparison in varied types of research studies.

A review of published oncology nurse navigation tools reveals the existence of a limited number of resources that vary in scope and purpose. In 2014, Lehigh Valley Health Network piloted an acuity scale in conjunction with a needs assessment to determine the need for navigation and the intensity of navigation required.⁹ Although the tool included multiple physical, emotional, and psychosocial factors, it did not account for staging, treatment (including multiple modalities), and specific psychosocial assessments such as the Patient Health Questionnaire (PHQ) 2/9—all of which are important when evaluating the level of support that patients will need during their cancer journey. Vidant Cancer

Care shared a comprehensive tool that focused on determining the amount of time each navigator needs to spend with each patient.¹⁰ Other oncology acuity tools also existed but were designed specifically for inpatient oncology care or were limited in the number of factors that determined acuity. Mitchell Cancer Institute did not evaluate those tools, because they did not specifically meet the needs of our outpatient setting or patient population.

We believed that Mitchell Cancer Institute needed an acuity tool composed of more specific patient factors than had been previously published, a tool specifically developed to deliver a much more comprehensive and accurate acuity of the patient. Recognizing that no tool existed with the generalized, yet flexible components we desired, Mitchell Cancer Institute began to develop a universal oncology nurse navigation acuity tool, designed not only to benefit Mitchell Cancer Institute’s practice but to also allow for adaptation and use by other cancer programs. The oncology nurse navigation acuity tool took approximately one year to develop, and though the tool was a collaboration of many, the primary authors were Diane Baldwin, manager of Clinical Care Coordination, and Thomas Butler, MD, supportive care oncologist at Mitchell Cancer Institute.

An Acuity Tool with a Holistic View

Mitchell Cancer Institute’s goal was to develop a tool that measured a patient’s acuity through a holistic lens. As most oncology providers know, each patient’s individual needs depend on a variety of factors. Often, these are factors that a time-constrained oncologist cannot address during a busy clinic schedule and, therefore, must rely on a navigation program to handle. Our task force examined the most common factors that determine a patient’s need and level of nurse navigation services required. Ultimately, we identified 11 factors that directly impact the need and level for nurse navigation services. As seen in Table 1, page 22, these 11 factors can easily be grouped into three major categories:

1. Cancer diagnosis and treatment.
2. Other medical and physical factors.
3. Psychosocial and emotional well-being.

We then developed the Mitchell Cancer Institute oncology nurse navigation acuity tool, incorporating these 11 factors as the foundation of the tool, using a 0 to 4 scoring scale with 0 to 1 equaling low acuity, 2 equaling moderate acuity, and 3 to 4 equaling high acuity. Acuity level 2 was determined to be the acuity at which patients need an average amount of navigation services and was therefore used as the comparison acuity score when determining the placement of factors within the tool during development. Therefore, each factor was evaluated on whether it would increase or decrease the amount of navigation services needed in comparison to the average navigation services needed for an acuity level or score of 2. Based on results from the comparison, each factor was placed in one or more acuity levels, with some factors (such as the PHQ 2/9 and Eastern Cooperative Oncology Group score) landing in multiple acuity levels.

Each acuity level was assigned a group of guidelines to help our oncology nurse navigators (initially titled clinical care coordinators) to determine the level of navigation services and resources needed for each patient. Figure 1, page 23, is the Mitchell Cancer Institute oncology nurse navigation acuity tool, which includes the 11 factors and guidelines for each level of acuity.

We believed that Mitchell Cancer Institute needed an acuity tool composed of more specific patient factors than had been previously published, a tool specifically developed to deliver a much more comprehensive and accurate acuity of the patient.

The use of 11 separate factors provides a holistic view of the patient, not a view based solely on a cancer diagnosis. Assigning acuity scores to patients based solely on clinical factors fails to consider other factors that greatly impact patients and that could be detrimental to the patient if not addressed. For example, two patients with the same type and stage of cancer, both receiving the same treatment, may present with different comorbidities and levels of family support, resulting in two very different acuity scores. Focusing solely on a patient’s disease is also why patients often feel that they are just another number. The ultimate goal of our oncology nurse navigation acuity tool is to combat this “just another number” phenomenon, by providing patients with holistic, individualized care based on their specific needs.

Once the navigation manager assigns a patient to a nurse navigator’s caseload, the navigator’s first task is to assess the patient—both by chart review and in person. After reviewing all 11 factors, the nurse navigator assigns the patient an acuity score by determining where the *majority* of the patient’s factors fall within the tool. If there are an equal number of factors in two different acuity scores, the higher score is initially assigned until further assessment is completed. The acuity score is reassessed when changes in treatment or staging occur, after hospitalizations, or when new or problematic factors arise that could result in a change in the patient’s acuity score. The acuity score is not assessed more than once per month and should be reassessed at least once every 6 months to ensure that the score accurately represents the patient’s current condition.

But Wait... Acuity is More Than Just a Number

An inherent weakness in most acuity tools is that the “score” assigned to the patient determines overall acuity. However, we know that our patients are more than just a number. Standardized tools often fail to identify important elements required to address individual patient needs. Often physical, emotional, and/or psy-

chosocial factors have significant impact on a patient’s care and need for navigation services. No tool can—or will ever—capture every possible factor. Therefore, our oncology nurse navigation acuity tool includes a unique 12th factor—the nurse navigator’s clinical assessment—to determine a patient’s final acuity score.

Mitchell Cancer Institute’s nurse navigators use the totaled score of the acuity tool’s 11 factors as a guide to initially assess the acuity of the patient and then, by using clinical judgment, combine this score with their overall clinical assessment to assign a final acuity score. The 12th factor of assessing the patient holistically is essential to accurately:

- Risk stratify the patient
- Assign an acuity score with the highest level of accuracy
- Fulfill our aim of providing holistic, high-quality, individualized patient care.

Ultimately, our nurse navigators may elect to change the acuity level based on their assessment of the individual patient. For example, let us compare two sample patients, Amy and Rae, who score identically on the first 11 factors within the tool. Both Amy and Rae have early stage breast cancer and are now postmastectomy. They both have taken letrozole for a year, both are in survivorship, and both have no major comorbidities. After all 11 factors are assessed, the nurse navigator determines that Amy has an acuity score of 0 and will only need navigation services upon patient request. Rae is also initially assessed as an acuity score of 0, but the nurse navigator learns during her visit with Rae that Rae’s husband has recently suffered a stroke. Rae has now taken a leave of absence from her full-time job to be her husband’s caregiver. Her husband is on disability, which is the

only income they currently receive. Although Rae’s PHQ depression screening was negative, she is experiencing a great deal of distress surrounding her husband’s condition, her ability to eventually return to work, their financial stability, and the unknown of what the future holds.

Although Rae’s cancer treatment and status are stable, she has significant stressors that, left unaddressed, can and will negatively affect her future treatment and care. The nurse navigator assigns Rae an acuity score of 2, because of the significant stress in her personal life. The nurse navigator will continue to keep in close contact with Rae and will reassess both her needs and acuity score as her personal situation continues to unfold. No matter how comprehensive or evidence based an acuity tool may be, we must always remember that no tool can completely replace the thorough assessment and clinical judgment of an experienced oncology nurse navigator. To provide exceptional quality-based care, we must always keep each individual patient at the center of any tool we create, any decision we make, and the care we provide.

Acuity Tool Validation: Initial Results

To determine the validity of the Mitchell Cancer Institute Oncology Nurse Navigation Acuity Tool, we retrospectively analyzed the nurse navigator documentation of a 247-patient caseload over the course of the first 6 months of 2017. All patients were assigned to the same nurse navigator’s caseload (eliminating variability among nurse navigators), and each patient was assigned an acuity score using the oncology nurse navigation acuity tool. The nurse navigator tracked all patient visits, phone calls, referrals, and interventions, differentiating between stat interventions and

Table 1. The 11 Factors of the Mitchell Cancer Institute Oncology Nurse Navigation Acuity Tool

Number	Factor	Category
1	Staging and diagnosis	Cancer diagnosis and treatment
2	Receiving multiple treatment modalities concurrently	Cancer diagnosis and treatment
3	Chemotherapy: multi-agent vs. single agent, vs. oral agents	Cancer diagnosis and treatment
4	Treatment status: new patient vs. active treatment, vs. survivorship, vs. end of life	Cancer diagnosis and treatment
5	Performance score: ECOG	Other medical and physical factors
6	Comorbidities	Other medical and physical factors
7	Hospitalizations	Other medical and physical factors
8	Colostomy, ileostomy, tracheostomy, feeding tube	Other medical and physical factors
9	Noncompliance with treatment	Other medical and physical factors
10	Family support	Psychosocial and emotional well-being
11	PHQ 2/9 depression screening	Psychosocial and emotional well-being

Figure 1. The Mitchell Cancer Institute Oncology Nurse Navigation Acuity Tool

Acuity Level	Guidelines and Considerations	Clinical Care Coordination Focus
0	<ul style="list-style-type: none"> In survivorship and stable Physician visits every 6–12 months Active treatment has ended (other than aromatase inhibitors or tamoxifen) Cancer in situ 	<ul style="list-style-type: none"> Meet with patient initially Treatment/survivorship plan developed/updated and reviewed with patient Provide initial education/clinical coordination/referrals and support Provide patient with contact information for care coordinator Follow-up provided as requested by patient
1	<ul style="list-style-type: none"> Stage 1 Single-agent chemotherapy Starting surveillance/observation Aromatase inhibitor or tamoxifen initially prescribed in past 6 months Performance ECOG = 0–1 PHQ 2 negative 	<ul style="list-style-type: none"> Meet with patient initially Treatment plan developed/updated and reviewed with patient Provide initial and ongoing education/clinical coordination/referrals and support Provide patient with contact information for care coordinator Monitor closely (at least every clinic visit) during the first 2 months and then as needed
2	<ul style="list-style-type: none"> New cancer diagnosis Stage 2 Multi-agent chemotherapy Oral chemotherapy Performance ECOG = 1–2 PHQ 9 score < 10 	<ul style="list-style-type: none"> Meet with patient initially Treatment plan developed/updated and reviewed with patient Provide initial and ongoing education/clinical coordination/referrals and support Provide patient with contact information for care coordinator Monitor closely (at least every clinic visit) during the first 4 months and then as needed
3	<ul style="list-style-type: none"> Hospitalized in past 60 days Receiving multiple treatment modalities concurrently (chemo, radiation, surgery) Serious comorbidities Head/neck/ gastrointestinal cancer diagnosis Colostomy/ileostomy Non-compliant with treatment Performance ECOG = 2–3 PHQ 9 score 10–20 Stage 3 disease Little or no family support 	<ul style="list-style-type: none"> Meet with patient initially Treatment plan developed/updated and reviewed with patient Provide initial and ongoing education/clinical coordination/referrals and support Provide patient with contact information for care coordinator Monitor closely (at least every clinic visit) during the first 6 months and then as needed Maintain phone contact with patient as needed in between visits Provide care coordination during transitions of care (hospital, home health, etc.)
4	<ul style="list-style-type: none"> Stage 4 disease Feeding tube Tracheostomy Frequent hospitalizations Unstable and/or end-stage disease Performance ECOG = 3–4 PHQ 9 score > 20 	<ul style="list-style-type: none"> Meet with patient initially Treatment plan developed/updated and reviewed with patient Provide initial and ongoing education/clinical coordination/referrals and support Provide patient with contact information for care coordinator Monitor closely (at least every clinic visit) during the first 9 to 12 months and then as needed Maintain phone contact with patient as needed in between visits Provide care coordination during transitions of care (hospital, home health, hospice) Provide end of life support to patient/family/caregivers as needed

clinical interventions. Stat interventions were defined as any intervention that directly prevented an ER visit or hospital admission. Clinical interventions were defined as any other intervention in which the nurse navigator clinically intervened in the care of the patient, resulting in a change of some kind for the patient (i.e., identification of a pertinent ordered lab from 3 weeks ago not drawn, brought to the attention of the clinical staff). The average monthly case mix by acuity level for the analyzed caseload was as follows:

- 2 percent low-acuity patients (score of 0 to 1)
- 69 percent medium-acuity patients (score of 2)
- 29 percent high-acuity patients (score of 3 or 4).

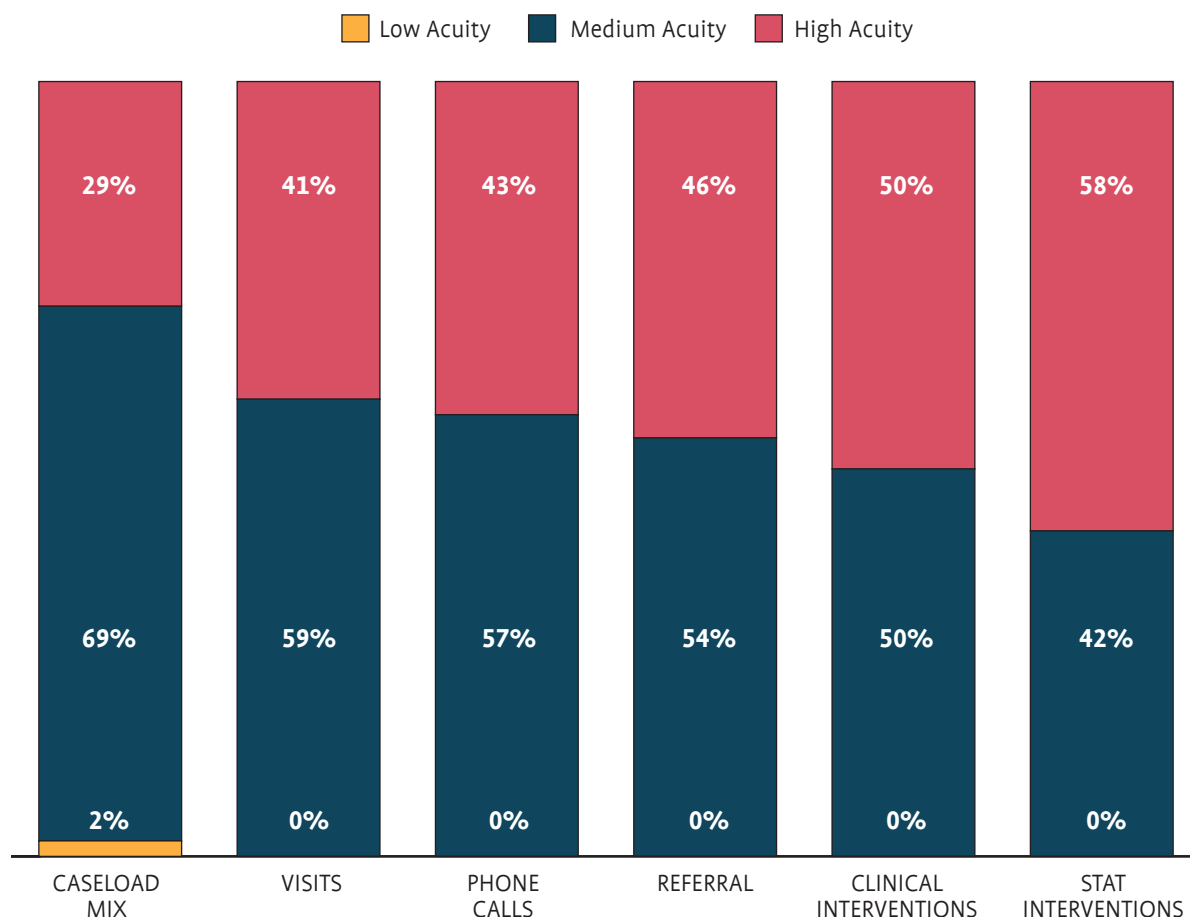
When the percentages of visits, calls, referrals, and interventions by acuity level were compared to the overall case mix percentages, we found that the high-acuity patients (score of 3 to 4) used more resources per patient than those assigned low- or medium-acuity scores. For example, even though only 29 percent of the total patient case mix was assigned a high-acuity score (3 to 4), these patients produced:

- 41 percent of all visits
- 43 percent of all phone calls
- 46 percent of all referrals.

Further, the data showed that the 29 percent of high-acuity patients accounted for 58 percent of the total number of avoided ER visits and avoided hospitalizations (stat interventions), which is the greatest testament of the Mitchell Cancer Institute oncology nurse navigation acuity tool to date. Figure 2, below, shows nurse navigation caseload mix compared to interventions.

Based on the small sample of data analyzed to date, the oncology nurse navigation acuity tool has proven to be effective for Mitchell Cancer Institute in determining which level of patients need navigation and the level of various navigation services required. Development and standardized use of this tool has equipped our nurse navigators with the ability to gauge how often patients need to be seen and provides them with an easy way to effectively manage their time. For our navigation manager, the tool offers a reliably accurate view of each navigator’s caseload, a view now based on acuity score rather than number of patients.

Figure 2. Nurse Navigation Caseload Mix Compared to Interventions



Caseloads are now adjusted when one navigator's caseload has a much higher acuity case mix than another. Assignment of caseload by number of patients alone is not a reliable method of caseload management. As our data have shown, the anticipated utilization of navigation services by a set number of patients may be quite different than the actual utilization of navigation services according to case mix acuity. This tool gives us the ability to visualize actual patient navigation resource utilization, a powerful set of data that reveals an accurate analysis of each caseload—information historically missing from navigation data collection. For administration, this tool:

- Offers a reliable analysis of Mitchell Cancer Institute's navigation services
- Provides a snapshot of how resources are being used
- Affords the ability to confidently make high-level practice decisions based on measurable data.


At Mitchell Cancer Institute, the tool has specifically aided in validating the need for expansion of nurse navigation services.

Going Forward

As we enter this new age of value-based care, we must be mindful stewards of resource utilization and spending as we continue to strive for excellence in patient care delivery. We must constantly seek to “transform the norm” in oncology care, with a goal of exceptional quality, while always keeping the patient at the center of all we do. Navigation services are an essential part of this mission, but it is critical that we utilize our navigators to the best benefit of both our patients and our practices so that these programs and services are sustainable over time.

Mitchell Cancer Institute's oncology nurse navigation acuity tool is easy to learn and use. It allows managers to efficiently assign and distribute caseloads and provides improved visibility of detailed, comprehensive caseload information. The tool can also be adapted to any type or size of oncology practice, making it a powerful resource if used correctly, due to its low cost and capacity to generate needed data, simplicity, and adaptability. Our nurse navigation team has successfully used this tool to prioritize their time and ensure that resources are used by the patients needing them most and at the times when patients are most in need.

Navigation services have advanced significantly over the past two decades, but a great deal of work remains to ensure navigation program sustainability for years to come. Our hope is that Mitchell Cancer Institute's oncology navigation acuity tool will not only be used by other cancer programs to successfully risk stratify patients but also will spark conversation and collaboration focused on—and potentially be used as a model for—the development of a standardized acuity tool. Collaborative development of such a tool that is inexpensive, user friendly, and easily customizable to any oncology practice would allow for improved efficiency and smarter utilization of both staff and resources. With the forthcoming addition of standardized national evidence-based

navigation metrics, oncology healthcare professionals will eventually have the means to measure and report standardized navigation outcomes. Ideally, use of a standardized acuity tool to easily collect and analyze data relevant to these upcoming navigation metrics will finally give oncology practices the concrete data critical to not only demonstrate the positive impact of navigation services on patient experience, clinical outcomes, and business performance but also to provide practices with the powerful ability to make sound, programmatic budgetary decisions based on performance data. Mitchell Cancer Institute believes that continuing to be innovative when needs arise, maintaining focus on cost-effectiveness, and optimizing use of readily available resources allows us to fight smarter and provide only the highest quality of services, while remaining competitive in today's value-based healthcare system. 

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Turning on the Light Switch





A model immunotherapy program at an oncology practice

During the past 3 years, medical journals have virtually exploded with headlines about immunotherapy and cancer, and it all started on March 25, 2011, when the U.S. Food and Drug Administration approved ipilimumab injection (Yervoy®) for the treatment of unresectable or metastatic melanoma. Though the breakthrough was huge news in the melanoma space, it had few immediate repercussions for the rest of oncology. That changed in 2015 with the approval of the PD-L1 checkpoint inhibitor nivolumab (Opdivo) for the treatment of patients with advanced non-small cell lung cancer. Most early studies found that checkpoint inhibitors showed all of the potential of earlier immunotherapeutic agents with far less toxicity. However, though immunotherapy is the biggest breakthrough in oncology in recent decades, this new treatment modality brings new toxicities for cancer patients.

Just as mainstream media was quick to herald the successes immunotherapy offered in the fight against cancer, so, too, was the media quick to report on its adverse effects. For example, a 2016 *New York Times* article shared the story of Chuck Peal, a patient on combination immunotherapy who found himself gravely ill in an emergency room and being treated by physicians

But by 2015, with our practice facing an unprecedented expansion of immunotherapeutic agents and indications and with the understanding that many of our physicians had never prescribed an immunotherapeutic agent, we realized that development and implementation of an immunotherapy program was not only a good idea but an immediate need to ensure safe, evidence-based treatment for our patient population.

unfamiliar with this class of medications.¹ Peal's cancer was gone, but the toxicities left him seriously ill and physicians baffled about what to do for him. The article quoted John Timmerman, MD, an oncologist and immunotherapy researcher at the University of California who had recently lost a patient to side effects of her immunotherapy treatment. He described his patient's response as "a mass riot, an uprising" of her immune system and went on to say, "We've heard about immunotherapy as God's gift, the chosen elixir, the cure for cancer. We haven't heard much about the collateral damage."¹

As these new therapies were more widely adopted, issues arose at emergency rooms (ERs) where immunotherapy patients were sometimes forced to go for treatment of toxicities. Even when immunotherapy patients informed ER staff that they were being treated with immunotherapy for cancer, ER staff often made the assumption that these patients were being treated with chemotherapy. Accordingly, pneumonitis was treated with antibiotics; diarrhea was treated with conventional methods. Situations like this were so alarming that pharmaceutical companies developed "wallet cards" as part of risk evaluation and mitigation strategy (REMS) programs so that immunotherapy patients had something to show healthcare professionals if they had an emergent medical problem.

Having accrued a high number of patients to the ipilimumab trials, Advocate Medical Group (Formerly Oncology Specialists S.C.), Park Ridge, Ill., had experienced its share of immune-mediated toxicities. In the beginning, these were isolated to melanoma patients, and research protocols were in place to assist with the challenges of managing the toxicities. But by 2015, with our practice facing an unprecedented expansion of immunotherapeutic agents and indications and with the understanding that many of our physicians had never prescribed an immunotherapeutic agent (Figure 1, page 29), we realized that development and implementation of an immunotherapy program was not only a good idea but an immediate need to ensure safe, evidence-based treatment for our patient population. As our immunotherapy program was being developed and in its infancy, professional organizations like Association of Community Cancer Centers,²⁻⁶ the Oncology Nursing Society,^{7,8} the National Comprehensive Cancer Network, and the American Medical Association also recognized the urgent need to educate and prepare clinicians to be ready to treat these immunotherapy patients.

Educating Our Staff

The first challenge we faced in the development and implementation of our immunotherapy program was how to most effectively and efficiently educate our medical staff. We addressed this through a peer-to-peer process. Physicians who were early prescribers of immunotherapeutic agents educated their peers and also reached out to the medical community as a whole. Understanding that support would be needed in many other medical specialties, including but not limited to endocrinology, gastroenterology, cardiology, pulmonary, dermatology, and emergency medicine, we also used this peer-to-peer process to educate our nurses. At the rate that immunotherapeutic agents are being approved and

introduced to the market, it is challenging to keep the entire staff—from physicians to the billing department—aware of all indications and the requirements for each indication. To help, our pharmacy department developed an immunotherapy flowchart (Figure 2, page 29). Our pharmacy staff frequently updates this tool, which is located on a shared computer drive for easy access.

Our oncology practice is modeled on a primary nurse system, so the same nurse treats the patient from start to completion of therapy. Policies and procedures support this model, with our treatment plans acting as the backbone to our treatments. These treatment plans give nurses orders for labs scans, dose reductions, supportive medications, and sequencing of medications. A new treatment plan was created for each immunotherapy regimen.

Accordingly, development of our immunotherapy program started at our practice's foundation: its policies and procedures. As in most oncology practices, our education focused on chemotherapy and biotherapy. Even our basic education information, such as reasons for patients to call the clinic, discharge instructions, and follow-up standards, were outdated and incomplete because they did not include immunotherapy. Every policy and procedure had to be updated to include immunotherapy. Most important, all staff and patient education resources had to be revised as well.

Developing a Robust Portfolio of Tools

As staff got to work updating existing information, we realized that though pharmaceutical companies had developed and published very good patient education materials on their specific medications and potential side effects, education on immunotherapy in general was sparse and not designed for the lay consumer. Thus, we first developed an introductory tool for patients that defined and explained immunotherapy (Figure 3, page 30). To help patients understand the importance of reporting adverse symptoms and side effects early, staff used the metaphor of a light switch. Immunotherapy turns on the light (i.e., the immune system) to fight cancer, which is good. However, sometimes our bodies cannot turn the light off when it starts overworking. If a light is left on, it burns out and so will organs affected by the immunotherapy. Adapting education material from Bristol Myers Squibb, the back of this tool features a diagram of the human body with corresponding side effects (toxicities) related to each organ. Nursing staff use this diagram and patient wallet cards to discuss specific toxicities and how to recognize them.

Next, we developed a tool to educate patients on when they should call the clinic. Specifically, our immunotherapy patients are instructed to call their nurse or physician if they experience any of the following:

- **Fever greater than 100.4°F with or without chills** not relieved when you take ibuprofen 400–600 mg or Tylenol 650 mg.
- **New onset cough or chest pressure.**
- **Shortness of breath** that is more than your usual way of breathing.
- **Diarrhea**; that is, more than three diarrhea stools per day that does not resolve with one dose (2 tablets) of Imodium-AD, or any blood or mucus in your stool.
- **Nausea or vomiting** that results in your inability to take in

food and fluids for more than 24 hours.

- **Changes in your vision** or increased sensitivity to light.
- **Skin rash** or intense itching without rash.
- **Extreme fatigue** that limits your normal activity.
- **Headache** not improved by normal remedy.
- **Muscle or bone/joint aches and pains** that are not relieved with pain medication.
- **Weakness in legs (feet) or arms (hands)**—difficulty doing your normal daily activities

Patients are given a clinic number to call 24 hours a day and told that if they call after regular hours and have not heard from a doctor within one hour to call again. Patients are also told that if they have symptoms that are worse than those mentioned above, they are to go immediately to the local ER and present a wallet card to let staff know that they are being treated with an immunotherapy agent.

At this point, staff realized that it would be necessary to document in the patient’s electronic health record (EHR) when patients received this education and instructions. Based on existing resources developed by various pharmaceutical manufacturers, we developed a patient immunotherapy checklist to use when patients are discharged from the infusion center (Figure 4, page 31). Patients fill out this checklist after their first infusion and then prior to each infusion thereafter. Staff enter the information into the EHR, and providers can then compare patient responses from one treatment to the next. This checklist triggers the conversation about toxicities and allows our staff to easily identify and address any changes.

Figure 3, page 30, is another education tool we developed for patients after they complete their first infusion. This tool lists the

Figure 1. Physicians at Advocate Lutheran General Hospital Prescribing Immunotherapy by Year

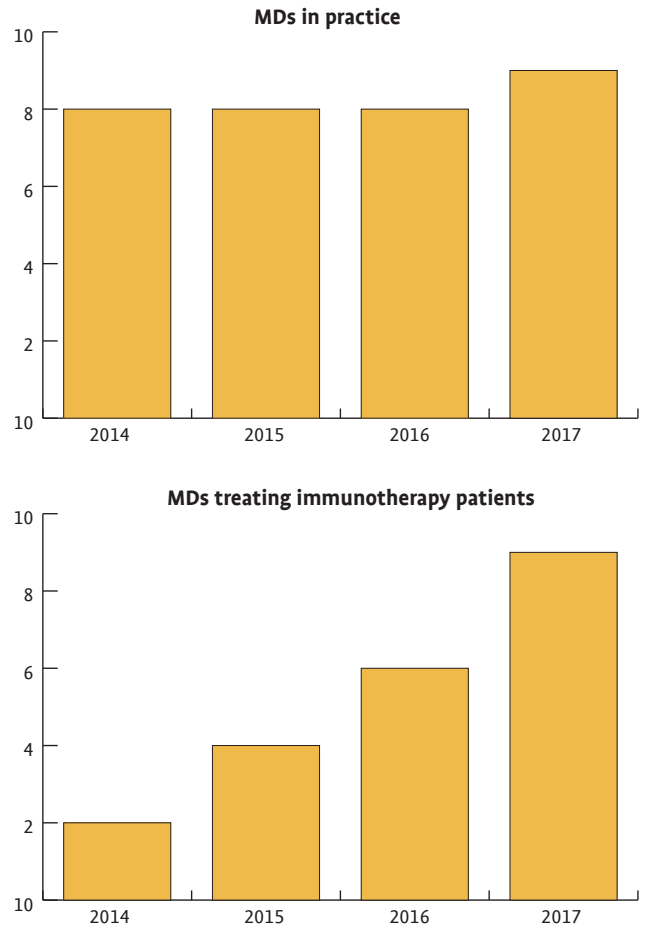


Figure 2. Immunotherapy Flowchart of FDA-Approved Indications

	Melanoma	NSCLC	HNSCC	Renal Cell Carcinoma	Classical Hodgkins	Urothelial Carcinoma	MSI-H	
pembrolizumab	Unresectable/ metastatic c	200mg q3w	200mg q3w**	200mg q3w		200mg q3w	200mg q3w	
nivolumab		240mg q2w	240mg q2w	3mg/kg q2w	240mg q2w	3mg/kg q2w	240mg q2w	240mg q2w
nivolumab + ipilimumab		nivo1mg/kg + ipi 3mg/kg						
ipilimumab	Adjuvant	10mg/kg q3w x4, then q12w						
atezolizumab		1200mg q3w				1200mg q3w		

** Tests + for PD-L1
 1st line NSCLC whose tumors have high PD-L1 expression (TPS ≥ 50%)
 2nd line NSCLC whose tumor have high PD-L1 expression (TPS ≥ 1%)

most common toxicities and practical ways for patients to respond to them before calling the clinic. This tool is located on our shared drive and is personalized for each patient and copied and pasted into their EHR at discharge.

Figure 6, page 33, is a form that our staff uses to document patients on dual immunotherapy (ipilimumab and nivolumab) for which the incidence of grade 3 and 4 immune-mediated toxicities is much greater. To address this increased chance of adverse toxicities, our treatment plan requires a weekly check on the patient for the first 15 weeks of treatment. Using this form, nurses perform a system-by-system weekly check either by phone or in clinic, at the discretion of the nurse.

As we developed and implemented our immunotherapy program, staff recognized that the treatment of immune-mediated toxicities with high-dose prednisone was not addressed in our treatment plan. Moreover, this information was difficult to document in the EHR so that all members of the care team are aware of what toxicity we are treating, the steroid dose, and taper schedule. To address these issues, our staff developed a steroid

taper treatment care plan. In brief, here's how this tool works.

Using this online tool, staff first identify the toxicity. Next, staff document the starting dose on prednisone. The treatment plan is in the EHR, so all physicians and nurses covering this patient are aware of the symptom dose and taper schedule. Patients are required to call the nurse with each dose decrease, and the nurse charts this interaction in the EHR so that the information is captured. All patients are prescribed prednisone 10 mg (so, for example, if the dose is 60 mg, patients take six tablets). For each prednisone dose entered, there is a corresponding notes section for staff to fill in with the appropriate information. For example, one note might read: LFT results at grade 1, so dose reduced to 40 mg daily.

Evaluating and Improving Our Immunotherapy Program

Our practice officially started its immunotherapy program in September 2016, and we evaluate the program and its tools on an ongoing basis. The importance of our immunotherapy program

Figure 3. Patient Education Sheet

Advocate Medical Group Oncology Specialties

What is Immunotherapy?

Immunotherapy uses your body's own immune system to fight cancer cells. This treatment is designed to produce immunity to a disease or enhance the resistance of the immune system to an active disease process, such as cancer. These medications include a family of drugs called checkpoint inhibitors. Your body has natural "checkpoints" in place to hold the immune system in check so it does not overwork.

These medications work by activating your T lymphocytes, the white blood cells that go after foreign invaders, to target the tumor cells.

This is like turning on the light switch.

It is important to know that once activated the light switch will remain on. This is necessary to have the greatest effect against your cancer. However, this may result in reaction against your normal healthy tissues.

So imagine if you turn on a light in your home and you cannot turn it off:

- Activating the immune system: immune therapy medications turn the switch on
- However, it also stops your body's natural ability to turn the switch off.
- Eventually, without some intervention, the light will burn out (can cause damage to your normal healthy tissue).

This is a very simple explanation of how immune therapy works in your body. It is very important that you communicate with your nurse and physician when any side effects occur.

Possible Side Effects

You may experience very serious side effects related to the immune activation. We want you to become familiar with what to look for to catch these reactions early.

Our goal is to **keep the light switch on** to have the greatest effect against your disease. However, normal healthy tissues can also react to this immune system activity.

Healthy tissues most often affected by the immune response are: the GI tract, especially the colon, liver, lungs, and nervous (neurologic) and hormonal (endocrine) systems.

Other general side effects include eye problems, fatigue, muscle/joint aching, and fever.

Mild side effects are expected. It is very important to report any moderate to severe symptoms to your doctor or nurse as soon as possible since they can get worse very quickly. Do not wait to call if symptoms get worse.

Figure 4. Patient Immunotherapy Checklist

NURSING IMMUNE-MEDIATED ADVERSE REACTION CHECKLIST

Patient Name: _____

Date: _____

Please complete prior to every dose.

Gastrointestinal (Digestive)	Response		Notes
	Yes	No	
Has your appetite changed?			
Do you have nausea or vomiting?			
How many bowel movements are you having a day?	Number:		
Is this different from normal?			
Are your stools loose or watery or foul-smelling?			
Do you have pain or cramping in your abdomen?			
Have you seen blood or mucus in your stools?			

Skin	Response		Notes
	Yes	No	
Does your skin itch?			
If yes, does it keep you up at night?			
Do you have a rash? If yes, where?			

Respiratory	Response		Notes
	Yes	No	
Do you have difficulty breathing or shortness of breath?			
Are you coughing?			
Do you have chest pain?			

Neurologic	Response		Notes
	Yes	No	
Are you having difficulty getting up from a chair?			
Do you have weakness in your hands, legs, or muscles?			
Are you having trouble with gripping, dropping, or picking things up?			
Are you having difficulty walking or are you unsteady?			
Are you having numbness or tingling in your hands or feet?			
Are you having problems with your memory or confusion?			
Are you having seizures or stiff neck?			

General	Response		Notes
	Yes	No	
Have you started taking new medications? (prescriptions, herbal, over the counter)			
Are you able to perform your normal activities?			
Are you having difficulty sleeping?			
Do you have headaches that do not go away?			
Have you felt dizzy or lightheaded?			
Are you bleeding or bruising more than usual?			
Are you having any flu-like symptoms? Fever?			
Do you have aching or weakness in your muscles or joints?			
Have you noticed problems with your eyes or vision?			
Have you noticed an increase in fatigue?			
Are you having changes in your libido (sex drive)?			

Figure 5. Patient Home Discharge Instructions

Advocate Medical Group
Formerly: Oncology Specialists
1700 Luther Lane, Park Ridge, IL 60068
7900 N Milwaukee Ave at 16 Niles, IL 60714
847.268.8200

PATIENT HOME DISCHARGE INSTRUCTIONS

Patient's Name: _____ Physician: _____
Therapy Date: _____ Nurse: _____

Immunotherapy Medications administered:

Reasons to Call:

1. Diarrhea
 More than 3 diarrhea stools in one day
 Any blood in your stool
2. Rash or itchiness
 Raised red rash with itching or itching with no rash
3. Shortness of breath, new cough, or chest pain
4. Flu-like symptoms that do not resolve
 Headache, fever, chills, joint pain
5. Any problems, questions, or concerns

Symptom Management Medications:

1. Imodium – 2 tabs after 1st diarrhea stool, 1 after each subsequent stool
 MUST CALL IF YOU NEED MORE THAN 2 DOSES
2. Ibuprofen – 3 tabs (600 mg); or acetaminophen 2 tabs (650 mg) every 6-8 hours as needed for headache, joint pain, chills, fever
3. Prochlorperazine (Compazine) 10 mg – take one every 6 hours as needed for nausea
4. Diphenhydramine (Benadryl) 25 mg – take 1-2 tablets every 6 hours for itching

Things to Remember

1. Drink plenty of fluids
2. Good hand washing
3. Sunscreen SPF 30 or higher

Call our 24-hour number with any problems, Monday-Friday 9 am-5 pm, and ask for your nurse.
After hours or weekends, ask for Dr. _____ or the doctor on call. 847.268.8200

cannot be overstated. In two short years, our practice went from two physicians ordering immunotherapy to 10 physicians ordering these cutting-edge treatments for their patients. Consistent use of the patient education tools we developed is key to our success and to ensuring that our patients have a good understanding of immunotherapy, its possible side effects and toxicities, and when to contact the clinic.

As part of our evaluation process, we gave 35 patients a set of scenarios and then asked them to check the box those that required them to call the clinic. Patients were correct 85 percent of the time.

We also asked our physicians, nurses, and patients to comment on the new immunotherapy program and the patient education

tools developed. Feedback was positive. For example, physicians shared that implementation of the steroid taper treatment care plan resulted in safer treatment care that is more seamless. Nurses agreed that the immunotherapy program helped with patient education and documentation, although they requested a few modifications; for example, “Fatigue” was added to the patient questionnaire checklist. Based on nurse feedback, we also developed a way to compare the patient questionnaire checklist from one treatment to the next, leveraging our EHR. Patients found the resources helpful and shared that these tools made it easy to review toxicities with medical staff.

The immunotherapy program has been in place for one year, and our practice is heading into its third round of evaluation.

Figure 6. Supportive Care Treatment Plan: High-Dose Steroids for Immunotherapy Toxicities

SUPPORTIVE CARE TREATMENT PLAN
High-Dose Steroids for Immunotherapy Toxicities

Name: _____ DOB: _____

Diagnosis: _____

Allergies: _____

Weight: 63.2 kg

Reason of treatment:

- Skin toxicities d/t immune-mediated rash
- Immune-related pneumonitis
- Diarrhea d/t immune colitis
- Elevated LFT d/t immune hepatitis
- Endocrinopathy (body joint aches, fever, headache)

Drugs:
 Prednisone (0.5mg – 1mg/kg) po 10mg take _____ tablets daily

Taper Directions: Reduce dose by 1 tablet

- q 3 days begin when rash and itching have resolved
- q 3 days if improved O2 sat, relief of SOB and/or cough
- q 3 days if no diarrhea or abdominal cramping
- weekly if LFT remain normal
- q 3 days begin when symptoms resolve


Requested Labs:	<u>Tests</u>	<u>When</u>
	Comp Panel	weekly (for hepatitis only)
	Quantiferon™ TB Golf (QUANTF) once for GI only	

Other: If high-dose prednisone is ordered, for GI toxicity, precert for infliximab

Required communication with MD or Primary Nurse: prior to each decrease in dose

Electronically signed by:

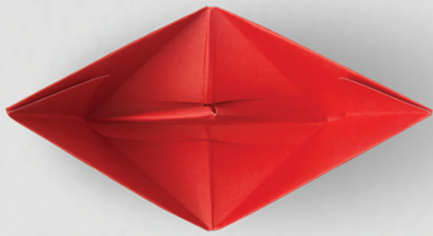
Date Signed:

The biggest takeaway from this program has been the importance for the medical community to stay up to date with medical science. We need to be open to change and well-read in order to give the best possible evidence-based care to our patients. 

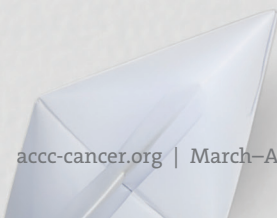
Ann McGreal, RN, is oncology nurse clinician at Advocate Medical Group, Park Ridge, Ill.

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Breast Care ACCESS Project



Leading efforts to improve access, timeliness, and coordination of breast care

We are experiencing a growing crisis surrounding disparities in breast cancer diagnosis, treatment, and survivorship. These ongoing disparities in cancer care delivery continue to impact patients and providers in our local communities, as well as our nation as a whole. Studies surrounding disparities in breast cancer care have been well documented and yet decades later we continue to struggle to improve these disparities through population-based healthcare efforts.

The breast program at Summa Health, Akron, Ohio, includes 2D and 3D mammography, breast magnetic resonance imaging (MRI), ultrasound, stereotactic and ultrasound breast biopsy, radioactive seed localizations, high-risk assessments, and survivorship surveillance. Patients typically access this care through preventative breast cancer screening. Eight Summa Health imaging sites offer patients access to screening services, with diagnostic services available at three centers. In 2013, Summa Health addressed disparity in breast cancer treatment head on with a 3-year process improvement project led by a dedicated multidisciplinary team of more than 30 participants.

Today, Summa Health is proud to offer *all* patients coordinated, timely access to high-quality, personalized care for any breast concern—from benign conditions to an abnormal mammogram, diagnosis, treatment, and survivorship—in a single location. New patients who are referred for a breast biopsy due to an abnormal breast finding at a diagnostic mammogram have access to specialty consults and care with a breast surgeon within 48 hours and *before biopsy*; remarkably, we have provided *same-day* surgical consults to 50 percent of the nearly 1,000 patients we see each year (Figure 1, page 37). Process improvement has allowed us to provide timely care for breast biopsies, averaging 11 total days between diagnostic mammogram and biopsy, a significant

The population in the community served by Summa Health, which includes three northeast Ohio counties, is at a higher risk for cancer based on race, behavioral, social, and environmental factors.

improvement from 26 days in 2014 (Figure 2, page 40). These improvements have allowed us to increase breast patient referrals for pre-biopsy surgical consult by 35 percent and reduce outmigration of diagnostic and biopsy patients (Figure 3, page 40). Here's the story of why and how we did it.

Disparities in Northeast Ohio

The American Cancer Society identifies Ohio breast and cancer mortality rates as higher than the national norm.¹ Ohio ranks above the national mortality rate for non-Hispanic black women who develop breast cancer. Additionally, women of Asian descent with breast cancer have a higher mortality rate in the state.

A 2015 Susan G. Komen Community Profile Report identified Ohio, most notably the northeast area of the state, as having a disproportionately high rate of breast cancer when compared to the rest of the states.² Northeast Ohio counties reported 3,470 new breast cancers, compared to 8,319 statewide, during the years 2006–2010. Fifty-three percent of the female population in northeast Ohio counties is over age 40, with mortality rates in breast cancer 42.4 percent higher for women in the northeast



In June 2015, Summa Health opened a new Breast Center designed to specifically deliver coordinated, patient-centered care where patients, families, and support persons could come together and participate in care planning and decision making. A specialty-trained breast-dedicated staff expedites diagnostic mammogram results, surgical consults and breast biopsies for all patients with a breast concern. Diagnostic and surgical suites interconnect to allow efficient and private patient flow between the suites.

part of Ohio compared the rest of the state. The Komen report highlighted possible barriers to access for breast screening, including a lack of awareness of the benefits of screening and resources for prevention, a lack of awareness of available resources for accessing care, a lack of transportation, and financial concerns.² The report suggested that these barriers could be impacted through patient navigation.²

Surveillance, Epidemiology, and End Results (SEER) data trends from 2010 to 2014 rank Ohio above the national rates for the following:³

1. Incidence of breast cancers for all races
2. Age-adjusted incidence for all ages
3. Age-adjusted mortality rates for breast/female cancers
4. Current smokers aged 18 and over
5. Lower reported figures for women aged 40–74 reporting having had a prior mammogram
6. Poverty for both families and individuals.

Disparities in Our Community

The population in the community served by Summa Health, which includes three northeast Ohio counties, is at a higher risk

for cancer based on race, behavioral, social, and environmental factors. Updated 2017 SEER data on cancer trends shows a continued increase in breast cancer incidences for both sexes.⁴ Cancers with the highest incidence rates in women are breast followed by lung and colorectal. The incidence is higher in black women. Mortality rates are highest for women with lung cancer, followed by breast cancer; white women have higher rates of mortality from lung cancer than black women, whereas breast cancer mortality remains higher for black women.

System Redesign: Breast ACCESS Project

In 2013 the Summa Health breast program leadership identified mammogram low compliance rates as a key population health initiative and launched a program to educate and inform our local community of the benefits of preventative imaging. Education focused on how early detection of breast cancer was possible with mammography and why early detection results in improved survivorship and a decreased mortality rate. Summa Health sent out 90,000 educational mammogram mailers to women in our community who had not had a mammogram in 2 years. We saw a 2 percent response rate, and 1,909 screening mammograms

were performed on individuals who received a mailer. Of these mammograms, 16 resulted in a breast cancer diagnosis (0.84 percent of all who received a screening mammogram). This preventative outreach program, which continues today, was a foundational piece in the redesign of our breast care program and served to strengthen Summa Health’s focus on quality breast health and care.

To coordinate, plan, implement, and evaluate process improvements to its breast program, Summa Health turned to the conceptual framework developed by the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) in its landmark report, *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis* (Figure 4, page 41).⁵

The Planning Process

The planning and discussion phase of the breast program redesign began concurrently in 2013 with the educational program. Summa Health identified breast program leadership, and these individuals began meeting regularly in 2014. Key components of the breast program redesign included the following:

- Improved access
- Timeliness
- Coordination with respect to prevention, treatment, and survivorship.

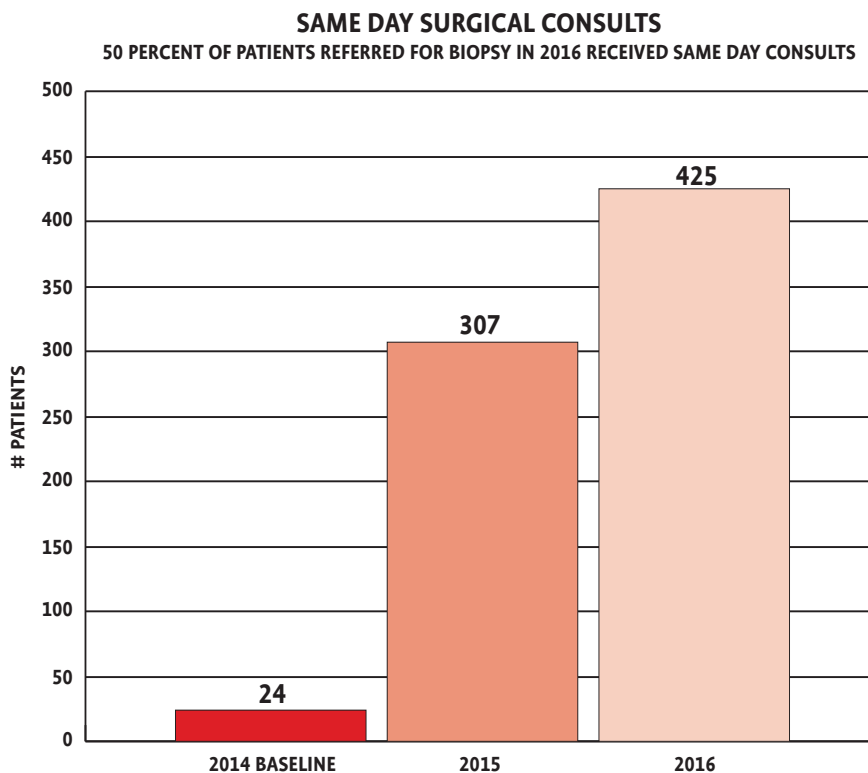
The team identified the following areas for process improvement: cancer disparities, incidence, late-stage diagnosis, and mortality. Improving access for breast care required Summa Health to identify and address structural, sociocultural, personal, and financial barriers impacting breast care delivery.⁶ The next step in the process was to survey patients and referring providers. Focus group discussions centered around challenges in breast care delivery, including timeliness, follow-up, care coordination, communication between providers, and difficulty in scheduling exams and time with specialists. Patients reported prolonged wait times between screening and diagnostic exams, exams and biopsy, biopsy and pathology, and pathology and surgical referral. Figure 5, page 41, highlights feedback from providers referring to Summa Health.

In 2014 Summa Health mined its data to create a baseline to be able to measure improvements. At that time, data revealed a 26-day wait from an abnormal diagnostic mammogram finding to the time a biopsy was performed (Figure 2, page 40).

Developing Program Goals

Next the team developed a goal for what it now called the ACCESS project: to improve access to coordinated, high-quality, team-based care for women with a breast concern—an abnormal mammogram, a palpable breast mass, or an increased risk for breast cancer due to high-risk pathology or family history. Phy-

Figure 1. Increase in Same-Day Surgical Consults





Physician champions led efforts to meet program goals, including (L): Melanie Lynch, M.D. surgical oncologist, medical director Summa Health Breast Program; (R): Lauren Kinsell, M.D., radiologist, medical director of Summa Health Breast Imaging.

sician champions led efforts to meet this goal, including the new medical director of the Breast Center, Melanie Lynch, MD, and Lauren Kinsell, MD, medical director of breast imaging. The team then established specific targets. The 7 Day ACCESS Goal, for example, aimed to reduce wait time between abnormal diagnostic mammogram finding to biopsy from 26 to 7 days. To do so, the team sought to schedule patients for a surgical consult within 2 days and for a biopsy within 5 days after the surgical consult.

In June 2015 the new Breast Center opened on the Summa Health Akron City campus, designed specifically to deliver coordinated, patient-centered care where patients, families, and support persons can come together and participate in care planning and decision making.

In 2014 Summa Health officially chartered a Breast Program Leadership Team. The team met monthly to coordinate plans for meeting the ACCESS project goals and to also improve accuracy and early detection and to reduce callback and error rates for exams. To achieve this, the team planned to leverage specialized breast care staff and new mammogram technology, including tomosynthesis and 3D mammography. With improved imaging technology and fellowship-trained or dedicated breast imaging radiologists reading all screening mammograms, Summa Health looked to realize earlier detection of abnormal findings.

Process Redesign

Spearheaded by the Breast Program Leadership Team, the ACCESS Project redesign required process improvement across the entire breast care continuum. To address structural barriers that impacted access to breast care, Summa Health planned to:

- Open a new Breast Center in June 2015
- Improve and expand screening and diagnostic services
- Develop and implement a stratified Summa Health interdisciplinary breast model
- Use specialty-trained breast-dedicated staff
- Expedite surgical consults
- Assign a dedicated imaging navigator role
- Hire a survivorship nurse practitioner.

To address patient-reported lack of timeliness in scheduling referrals and biopsies and to improve coordination of services, Summa Health planned to:

- Improve referral to specialty providers with increased same-day follow-up
- Expand its navigation process
- Implement community and provider education and outreach using liaisons to communicate expanded services, redesign, and available resources
- Expand survivorship and high-risk supportive programming.

To address sociocultural, personal, and financial barriers, Summa Health planned to:

- Hold community stakeholder focus groups with patients and providers to increase engagement in redesign and process improvement planning
- Increase community outreach with an “always on” integrated cancer screening campaign

Breast care navigation is coordinated in the Summa Breast Center by (R): Sharon Lieb Inzetta, RN, MS, CBCN, CN-BN, ONN-CG the Nurse Coordinator Breast Health and (L): Heidi Eve-Cahoon MSN, CNP the Survivorship Navigator.



- Strengthen community partnerships to improve awareness of and coordinate resources for patients, for example, the Summa Screens Program through Susan G. Komen® Northeast, the Ohio and Pink Ribbon Summit County BCCP Provider, and the Summa Health Women’s Board and Hospital Foundation
- Develop education materials that are culturally sensitive and evidence based.

Opening the New Breast Center

In June 2015 the new Breast Center opened on the Summa Health Akron City campus, designed specifically to deliver coordinated, patient-centered care where patients, families, and support persons can come together and participate in care planning and decision making. At 5,000 square feet, the Breast Center features a “spa-like” atmosphere where patients have easy access to diagnostic, surgical, high-risk, and survivorship services. Six spacious exam rooms facilitate multidisciplinary care. The surgical space in the Breast Center can accommodate two surgeons and a nurse practitioner. The imaging suite is connected, allowing patients and staff easy access for questions and patient follow-up.

The diagnostic side of our Breast Center has registration and changing areas where patients can wait in comfortable, custom-designed robes. The Summa Health Women’s Board provided funding for these robes, and patients have shared positive feedback on the comfort and “spa-like” feel they provide. Diagnostic services include four mammography and three ultrasound rooms. Stereotactic, ultrasound, and radioactive seed placements are done in the Breast Center. Two radiologists—one dedicated to diagnostics and screenings and one performing biopsies and placing radioactive seeds—see patients daily. An elevator located in the Breast Center connects to the MRI suite on the ground floor where MRI biopsies are performed. Open communication

back and forth between diagnostic and surgical services promotes increased care coordination and patient-centered care.

In 2015 Breast Program leadership adopted a policy that required new patient referrals for a breast biopsy or patients with an abnormal breast finding to have access to surgical specialty care within 48 hours. To support this goal, the breast cancer is staffed daily with a surgeon. Summa Health tracked breast cancer patient data in 2015 and compared it to 2014 baseline to analyze the impact of its new Breast Center and progress toward ACCESS goals.

Breast Program leadership also received system leadership approval to expand navigation services in 2014. As a result, a dedicated imaging navigator and a breast care coordinator position was created that fall, and the team began tracking data related to these services in January 2015. This team was tasked with expanding services and improving the screening and diagnostic patient experience. To do so, the team:

- Implemented an oncology nurse navigation model of care that was grounded in the work of Katharine Kolcaba, PhD, MSN, RN, and her patient-centered theory of comfort model⁷ (Figure 6, page 43)
- Created a diagnostic plan of care for any patient recommended for follow-up by our radiologist after breast imaging
- Developed culturally sensitive educational materials for breast health, abnormal breast findings, and breast biopsy
- Implemented ACCESS outcome measures for navigation including patient referral volume, days to surgical consult and outmigration care
- Developed metrics and analytics to monitor process involvement.

ACCESS Project Outcomes

After only 3 months, the new navigation process resulted in significant improvements in patient volume, including a decrease

Figure 2. Reduced Wait Times from Mammogram to Biopsy

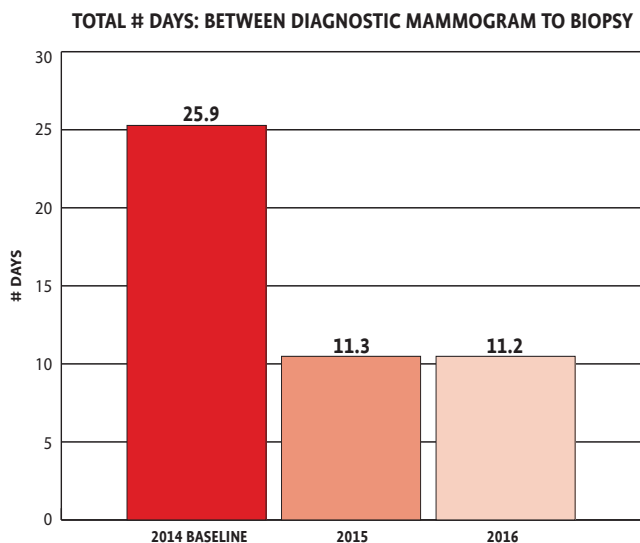
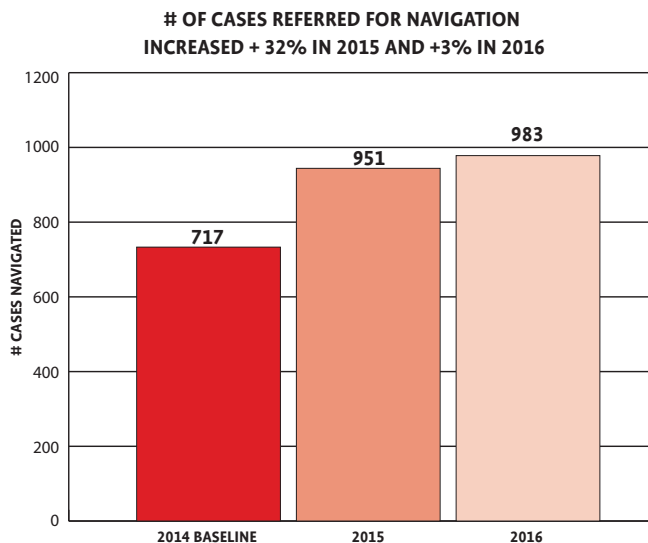


Figure 3. Increased Referrals to Navigation



in patient outmigration and an increase in patients being referred to navigation. Prior to having a dedicated imaging navigator, a significant number of patients left the Summa Health system or were lost to follow-up. Outmigration declined from 5 percent of patients referred for biopsy to 0.6 percent (Figure 7, page 43). Summa Health also realized increases in overall volume for surgical referrals prior to biopsy during the first year of expanded navigation services with 951 patients referred a 31 percent increase, (Figure 3, above). All referrals were followed by tracking these metrics: follow-up for compliance surrounding biopsy, follow-up imaging, concordance, and pathology. Timeliness, care coordination, and satisfaction all improved. Time to surgical consult, time to biopsy, and time to pathology all showed significant improvement. Additionally, provider satisfaction improved.

Breast Program leadership received monthly navigation reports. Increases in overall volume after the first year of navigation demonstrated significant financial return to the Summa Health, allowing for the hiring of a second imaging navigator. Volume continues to increase in all areas, including timeliness in care delivery. By 2016, referrals had increased by 35 percent (Figure 3, above), and same-day surgical consults for patients recommended for biopsy at their diagnostic mammogram had increased almost 50 percent (Figure 1, page 37).

Timeliness for care has been demonstrated by continually increasing the number of patients presenting for imaging, seeing a breast surgeon, and having a biopsy within the same day (Figure 1, page 37). Total days between diagnostic mammogram and

biopsy declined to 11.2 days, a significant improvement from 26 days in 2014 (Figure 2, above). Because days from surgical consult to biopsy consistently averaged to 7 to 8 days versus our target of 5 days, we conducted a patient and imaging technician survey to determine how to improve our timeliness in this area. We found that the delay in biopsy was due to patient preferences—not our ability to offer and schedule more timely appointments.

While the ACCESS Project was underway, our Breast Center transitioned to an electronic health record (EHR) in 2015 and flow sheets specific to cancer care were developed. The Breast Center adopted a screening and surveillance program built into Epic for the ongoing prevention of lymphedema throughout survivorship. The EHR is critical to providing patient-centered, coordinated healthcare among a multidisciplinary team of providers. It allows for more timely and accurate reporting for our interdisciplinary team. Primary care, surgical, oncology, pathology, radiology, navigation, survivorship, physical therapy, nutrition, social work, spiritual, palliative, genetics, and financial—all have access to the EHR.

In 2016 Summa Health expanded its survivorship services. Under the leadership of Dr. Lynch, a nurse practitioner now heads up our survivorship clinic. The nurse practitioner has a direct referral link in the EHR so that she can now receive referrals and bill for her services. During the survivorship visit, the nurse practitioner completes the survivorship care plan, reviews the plan with the patient, and makes surveillance recommendations. We have found that this survivorship nurse practitioner closes

Figure 4. IOM Conceptual Framework for Improving the Quality of Cancer Care

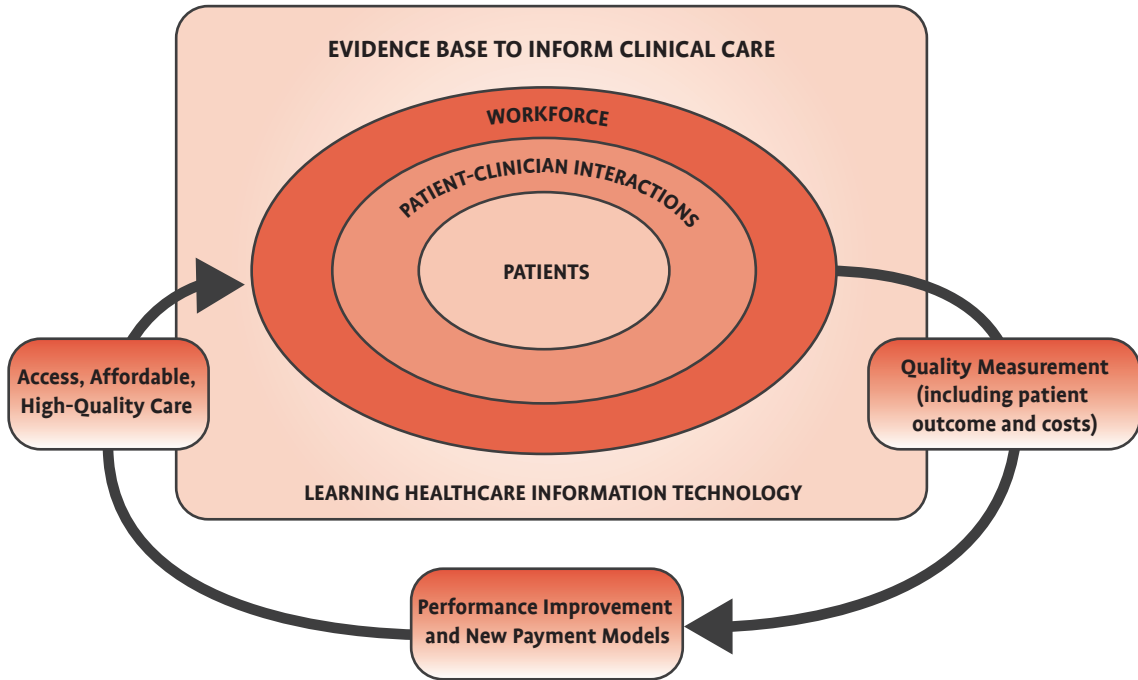
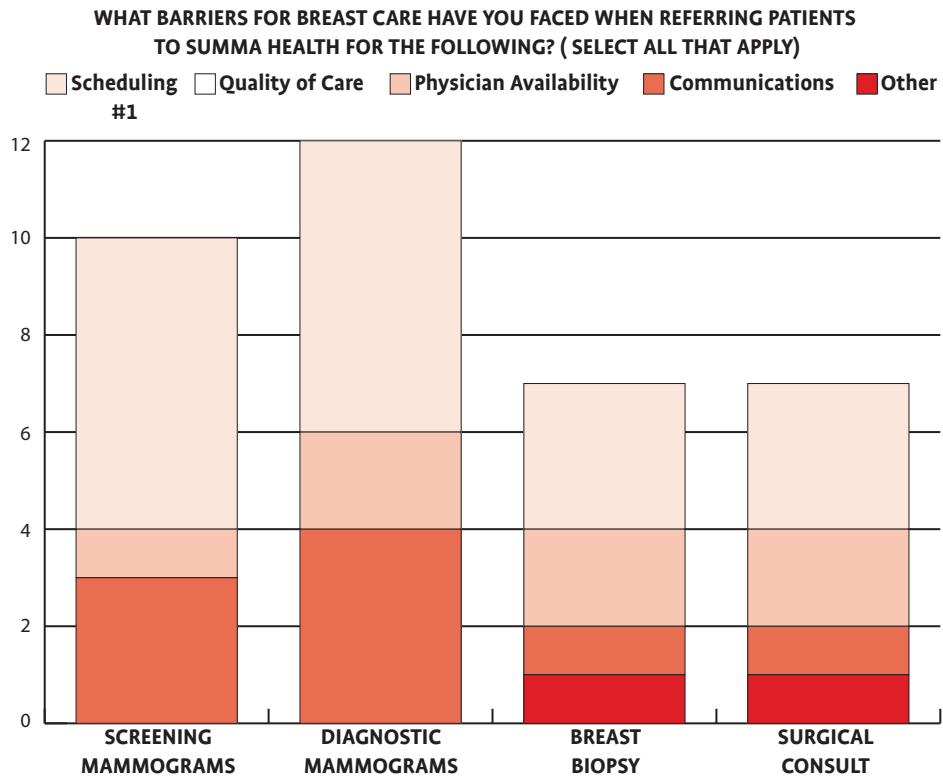


Figure 5. Question from Breast ACCESS Project Voice of the Customer and Referring Physicians Surveys




the loop at Summa Health, allowing us to provide well-coordinated, timely, and patient-centered breast care for all patients.

In February 2017, after 3 years of hard work by our team, our collaborative effort to implement process improvement was rewarded with NAPBC accreditation for the Summa Breast Program in Akron.

A Look to the Future

A recent article discussed the challenges today's cancer programs face in providing access to high-quality patient-centered cancer care.⁸ Health systems are beset by escalating costs while simultaneously shifting from fee-for-service to value-based payment models. Balancing costs while maintaining quality, though difficult, will ultimately be required of all cancer programs.

To continue to grow, our breast program will need to expand its outreach and access to counties with higher rates of late-stage diagnosis and aging populations. We will also continue to target disparities in the state and adapt to meet the needs of our aging population with multiple comorbidities. This population will require continued outreach and education targeting cancer prevention and healthy lifestyle behaviors. 

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Our Program and Community At-a-Glance

Summa Health is one of the largest integrated healthcare delivery systems in Ohio. Formed in 1989 with the merger of Akron City and St. Thomas Hospitals, the nonprofit system now encompasses a network of hospitals, community-based health centers, a health plan, a multispecialty group practice, an accountable care organization, research and medical education, and a foundation.

Today, Summa Health, the largest employer is Summit County, provides care to more than 1 million individuals across three northeast Ohio counties and covers nearly 74,000 people through our health plan. Summa Health contributes \$2.7 billion in business volume impact to the Ohio economy. With more than 1 million patients and more than 7,000 employees, Summa Health provides the highest quality patient-centered, compassionate care for our communities.

The 2016 U.S. Census figures reported for Akron, Ohio, show a population of about 197,000 individuals.¹ Akron is located in Summit County, the fourth-largest county in Ohio, and it is the fifth-largest city in the state. The population is 52 percent female, 62 percent white, and 32 percent African American. Most recent poverty figures are at 27 percent; the national poverty rate is 14 percent. Mean household income is reported at \$34,500, with median home values at \$81,000. Eight-six percent of the residents graduated high school, and the average household has 2.3 persons. Principal industries are manufacturing, healthcare, retail, and wholesale.

Reference

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Figure 6. Oncology Nurse Navigation Model of Care

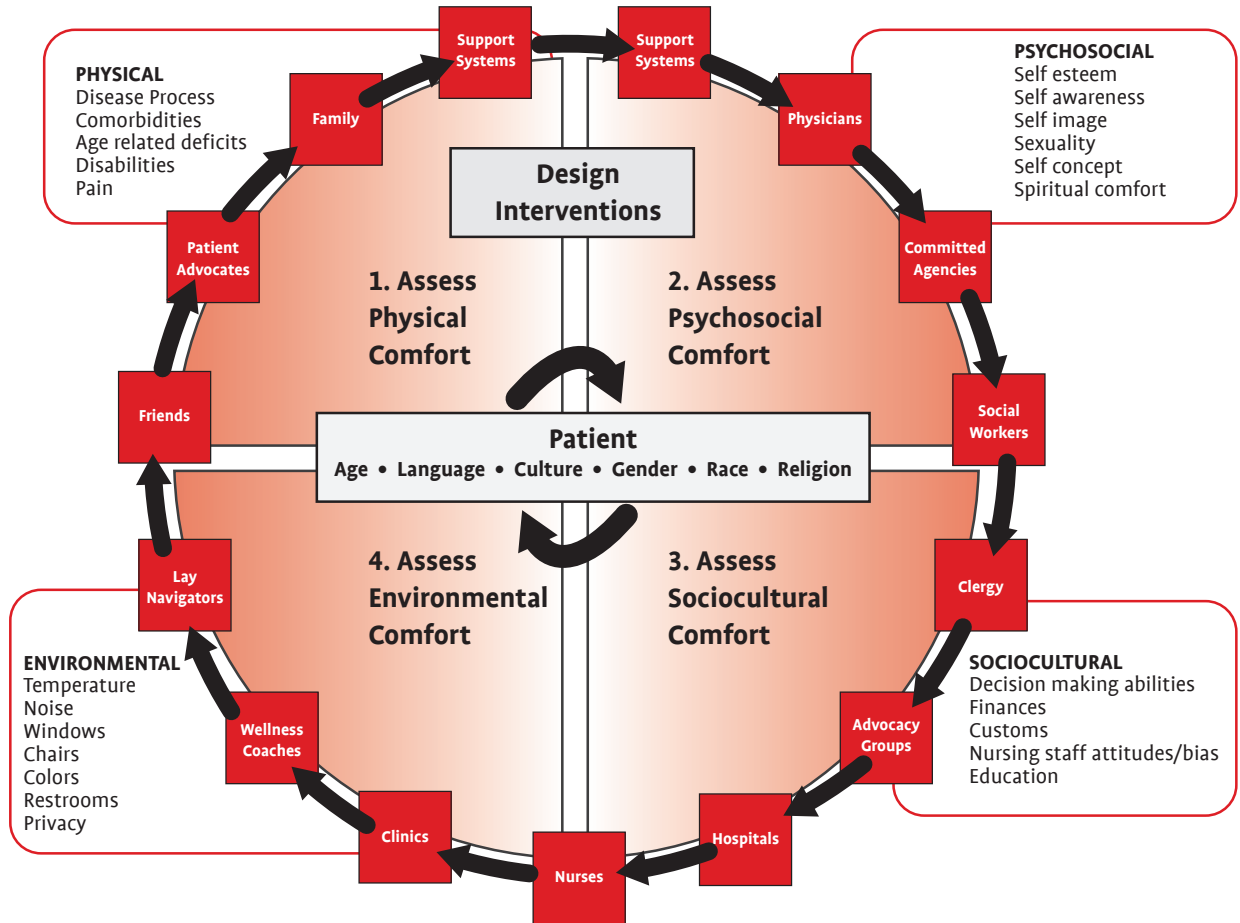
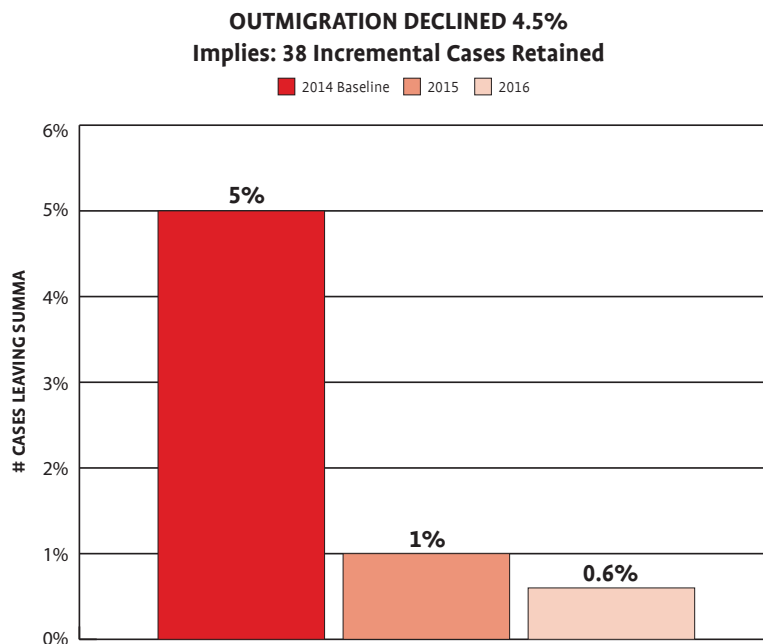


Figure 7. Improvements to Outmigration



IMPROVING POPULATION-BASED HEALTH AND REDUCING DISPARITIES IN BREAST CANCER CARE

One of the earliest studies of breast cancer life expectancy rates was conducted at two hospitals, Huntington Memorial Hospital and Pondville Hospital, both in Boston, Mass.¹ These hospitals compared yearly rates from 1912 to 1922 and 1923 to 1932. Differences in survival rates were noted within the different populations and between the two systems. Reported life expectancy from 1912 to 1932 was 3.5 years from the onset of disease for those treated at one of the two hospitals studied; untreated patients had a life expectancy of 2.5 years. Prognosis for breast cancer patients treated at Huntington Hospital during that time improved by 16 percent. Investigators concluded that the patient population served had transitioned and that the sicker terminal patients had been treated at the Pondville Hospital. They further found that older patients were less likely to go to the hospital for treatment and, when admitted, they presented with a much later stage of cancer. This very early study illustrates disparities in cancer care and treatment that still persist today.

A Pioneer in Disparities and Patient Navigation

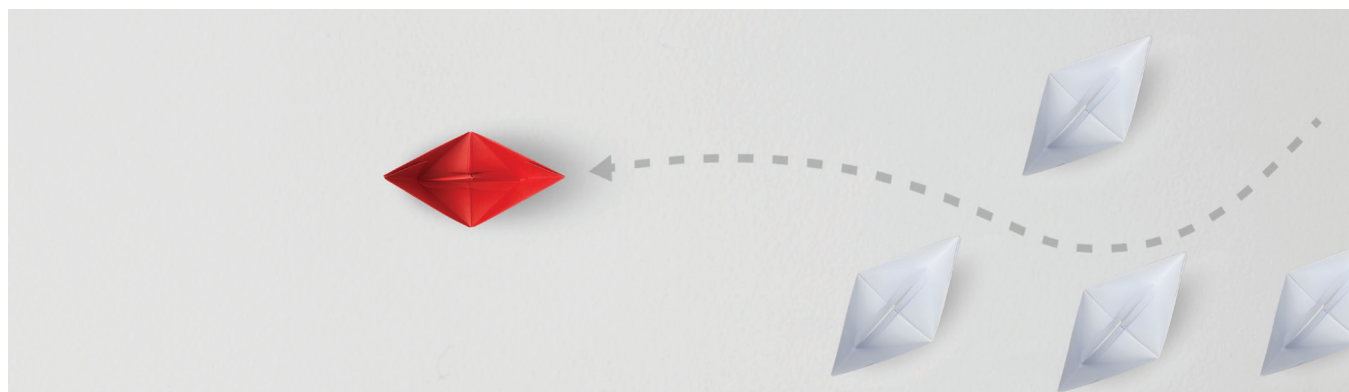
In the late 1980s Harold P. Freeman, MD, created the Harlem Cancer Education and Demonstration Project, which targeted low-income, underserved minorities presenting with late-stage breast cancers.² Dr. Freeman developed a model that identified three objectives:

1. Expand cancer screenings for the lower-income black population
2. Use a patient navigator to coordinate care delivery
3. Expand educational and outreach activities to the local lower income community.

Dr. Freeman maintained that early cancer detection and decreased mortality required the following:

- Outreach and education for high-risk populations to increase cancer screenings
- Increase ongoing health-seeking behaviors with a focus on regular preventative cancer screenings
- Remove barriers and increase access to cancer screenings and diagnostic workup following abnormal findings or a cancer.

Dr. Freeman developed the first patient navigation model that demonstrated the difference in patient outcomes for those with navigators and those without. Navigational care was shown to increase compliance and decrease delays in the breast care process.



Strategic Objectives to Improve Care Delivery

A 2012 national healthcare disparities report discussed disparities in the United States with respect to healthcare access.³ The poor—who lacked access to healthcare—experienced worse outcomes, and these outcomes translated to society as a whole. Specifically, the poor were found to have a higher burden for disease, incurring both local and national costs. Chronic and late-stage diagnoses created added cost nationally.

The *2015 National Healthcare Quality and Disparities Report* outlined wide national variation on quality in healthcare, care coordination, patient-centered care, and affordable care.⁴ Race and socioeconomic status impact both access to and quality of healthcare. The report identified three strategic objectives for improving population health and our healthcare delivery system:

1. Better care with improved overall quality of care delivered through easily accessible, safe, patient-centered care models
2. Healthy people and healthy communities with improved overall health of the U.S. population through interventions targeting behavioral, social, and environmental variables
3. Affordable care with national delivery to all groups.

Improving Population Health: Screening

The National Cancer Institute (NCI) Cancer Trends Report⁵ outlines the benefits of breast cancer screening, which is recommended as a Healthy People 2020 Initiative.⁶ The recommendation called for 81 percent of women aged 50 to 74 to have a screening mammogram based on the most recent guidelines. The report estimates that in 2015 there was 71.6 percent compliance with this initiative. Differing guidelines to different communities can create confusion and barriers to care among both patients and providers. Women may experience confusion regarding when they should initiate a mammogram and when to stop preventative screenings.

The Health Policy Institute of Ohio outlined initiatives for the improvement of our state's care infrastructure.⁷ The intended goal was to improve the health of Ohioans by employing evidence-based population health activities for healthier outcomes.

Ongoing challenges in delivering breast care were also discussed in the Institute of Medicine (IOM) 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, which outlined major challenges remaining in cancer care delivery.⁸ The report finds that a redesign for systemic effectiveness was warranted. Redesign would require aligning best practice guidelines with supportive information systems.⁸ The IOM report argues that healthcare that is well coordinated and collaborative reduces errors and waste, lowers costs, and results in better overall patient outcomes.⁸

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Life with Cancer at Inova Schar Cancer Institute



Competency, creativity, community

Life with Cancer is the psychosocial and educational arm of the Inova Schar Cancer Institute within the Inova Health System in northern Virginia. For nearly 30 years, Life with Cancer has transformed community cancer care by turning evidence-based research into unique and innovative services. Conceived from one man's vision, Life with Cancer has become a leading cancer care education and support program in the metropolitan Washington, D.C., area. (For more about the birth of this program, see "The Power of a Single Seed," page 53. Every day, our team works together to improve the psychological and physical health of people affected by cancer. We also continually explore ways to expand our services through programs on information, education, healthy living, yoga and exercise, stress management, and support groups, as well as programs for our special populations—children and adolescents, young adults, and Spanish-speaking families.

The House That the Community Built

The Dewberry Life with Cancer Family Center, also known as "Carolyn's House," is a 17,000-square-foot home-like setting in the heart of Fairfax, Va. Opened in 2009, it serves as the hub for Life with Cancer services. The main campus of the Inova Schar Cancer Institute is nearby, which makes the Life with Cancer Family Center convenient to access for patients and families.

The Family Center was created with the inspiration (and perspiration) of many caring individuals in the community, includ-

Life with Cancer includes a multidisciplinary team of more than 40 staff, including a psychiatrist/psycho-oncologist, oncology nurse navigators, licensed clinical social workers, licensed professional counselors, licensed art therapists, fitness instructors, and administrative staff.

ing Milt and Carolyn Peterson and Sid Dewberry. Designed to have a residential look, the Family Center provides a serene and healing environment where people gather to receive support services, attend programs and classes, and address needs and concerns with highly skilled clinical staff.

Of note is the Great Room, which can accommodate up to 100 participants; a beautiful library; and the children and adolescent areas with both play and art therapy rooms. The lower



The Dewberry Life with Cancer Family Center, also known as “Carolyn’s House.”

level garden room looks out on a healing garden with a stone pond. This area offers space for a variety of exercise classes, as well as yoga, Reiki, and relaxation.

Competence, Creativity, Community: Keys to Success

Life with Cancer includes a multidisciplinary team of more than 40 staff, including a psychiatrist/psycho-oncologist, oncology nurse navigators, licensed clinical social workers, licensed professional counselors, licensed art therapists, fitness instructors, and administrative staff. Oncology therapists and oncology nurse navigators possess diverse skill sets and specialized training that enables them to meet patients’ needs throughout the care spectrum—time of diagnosis, active treatment, advanced disease, survivorship, end-of-life experiences, and bereavement. These staff members can provide guidance and intervention strategies, including cognitive behavioral therapy, art therapy, mindfulness training, trauma care, techniques and resources to promote sexual health, and strategies to manage insomnia and cognitive impairment.

Oncology nurse navigators and oncology therapists work together and cofacilitate networking and support groups, as well as collaborate on psychoeducational programming on topics like sexual health and treatment side effects. According to Drucilla Brethwaite, MSW, LCSW, OSW-C, Director for Life with Cancer, this co-facilitator model ensures both educational and psychosocial needs are met. “When a patient is distressed in a group, it may stem from a lack of medical information or a psychosocial issue. Having an oncology nurse navigator and oncology therapist in our groups can help to quickly identify what’s causing the emotional distress and provide appropriate information and/or intervention strategies to help better manage the situation.”

Life with Cancer programs are research informed, and we collaborate with the Inova Schar Cancer Institute research team to keep our practices current. We offer an adolescent and children’s program, disease-specific support groups, and groups for caregivers and young adults. We also provide general wellness classes, such as exercise therapy, and integrative approaches, including mindfulness training, meditation, Healing Touch, and yoga. Currently,



The healing garden, which includes a stone pond, offers a quiet and reflective area for patients and visitors of the Life with Cancer Family Center.

we offer more than 200 classes for adults, young adults, adolescents, and children each month.

From its earliest days, Life with Cancer staff built an innovative foundation of collaboration with the Inova Health System, community leaders, the public school system, area organizations, and healthcare providers that continues to support our work today. Life with Cancer programming is provided at the Family Center, as well as at Inova's five area hospitals alongside a pediatric oncology center, three infusion centers, and five radiation oncology departments. However, cancer patients and their families can use Life with Cancer services regardless of where patients receive treatment. All programs, services, and classes are free of charge, except for massage and psychiatry services.

Leadership Buy-In

Another key to Life with Cancer's continued success is the enthusiastic support from Inova leadership, led by J. Knox Singleton, CEO, Inova Health System, and Donald "Skip" Trump, MD, CEO, and executive director, Inova Schar Cancer Institute. "Every cancer program provides some form of psychosocial support, and most recognize how important these services are," says Dr.

Trump. "What is unique in my experience about Life with Cancer is its start as a philanthropic project; its growth into a comprehensive, self-directed program; and its relationship to Inova. Life with Cancer's leadership recognizes the importance of community links. It reaches beyond philanthropy to advocate for and improve understanding and support for cancer patients and families in the community." With cancer as the leading cause of death in Northern Virginia—according to the Northern Virginia Health Foundation—this role is more important now than ever before.

Programmatic Benefits

Our Life with Cancer program has been instrumental in helping the Inova Schar Cancer Institute meet Commission on Cancer (CoC) standards for distress screening and community outreach and education. For example, Life with Cancer staff collaborate with staff at Inova Schar Cancer Institute to complete and deliver survivorship care plans. Data gained from distress screenings and problem checklists have helped support the value of psychosocial support for patients and drive future programming needs. Meeting CoC standards improves clinical practice, patient care, and patient outcomes. Distress screening enables staff to quickly identify



With more than 200 classes a month, Life with Cancer includes options for adults, young adults, adolescents, and children. Clockwise from top left: Restorative yoga for children, adult exercise, educational class and the sand tray for child therapy.

patients who will benefit from various Life with Cancer programs and decreases patient and family distress, which can improve quality of life, increase adherence to treatment, and decrease physical and psychological symptoms.

Life with Cancer also supports Inova oncology staff with in-services, processing groups designed to enhance quality care and decrease compassion fatigue, and assistance with system-wide initiatives. A Life with Cancer staff member is trained as a Schwartz Rounds facilitator, a national program to promote compassionate healthcare between patients and healthcare providers. With the collaboration of Inova leadership, Life with Cancer programs make a significant difference in the lives of patients, families, and Inova's oncology staff.

Expanding and Sustaining an Integrated Team

Life with Cancer's success derives from providing evidence-based, integrated, coordinated psychosocial support. "Cancer care support can be disconnected and uncoordinated in some communities," says Thomas Graves, vice president for Cancer Services and associate director for Administration, Inova Schar Cancer

Institute. "For example, athletic clubs without a cancer identity may offer an exercise support program for cancer patients. Family support services may be offered somewhere else. Here, we have a central facility, the Family Center, which is outside the stressful environment called 'healthcare' that is so familiar to cancer patients and their families."

The Executive Director of Life with Cancer is part of the Inova Schar Cancer Institute leadership team and meets with Cancer Institute administrators weekly. "We look to Life with Cancer leadership to learn what our patients are experiencing as they go through our healthcare system," says Graves.

Life with Cancer oncology nurse navigators and therapists in each of our five community hospitals have broadened our point of contact with cancer patients in the Washington, D.C., region. Nurse navigators educate patients about their diagnosis and treatment plans and answer questions. Together with psychiatrist Sermsak Lolak, MD, navigators triage cancer patients and families, identify those who may benefit from Life with Cancer support, and explain the program and services available. Dr. Lolak was hired by Life with Cancer and the Inova Schar Cancer Institute

Life with Cancer Fundraising Activities—Something for Everyone

- *Joan Hisaoka Annual “Make a Difference Gala.”* 2017 marked the 10th anniversary of the “Make a Difference Gala,” in memory of Joan Hisaoka, to assist those living with cancer. Last year’s event raised \$919,000; Life with Cancer was the primary beneficiary of the event.
- *Annual Lobster Extravaganza.* More than 1,000 community members eat lobster and steak during this casual event, which has been a community favorite for 19 years. Members of the Fairfax Fraternal Order of Police set up tables and chairs, and Life with Cancer volunteers work as wait staff with Foster’s of Maine to serve food. A silent and live auction, as well as live music, is part of the festivities.
- *The Annual Clifton Lions Labor Day Car Show.* Life with Cancer is a beneficiary of the Annual Clifton Virginia Lions this event, which last year raised \$141,968 for Life with Cancer programs.
- *Fairfax Fraternal Order of Police.* Cancer is personal. Several years ago, five members of one precinct in the Fairfax Fraternal Order of Police developed cancer in a short period. Three died. Life with Cancer supported the precinct during its cancer struggles. Dr. Trump spoke at a precinct meeting and arranged for special cancer education presentations by Inova Schar Cancer Institute experts. The Fairfax Fraternal Order of Police made a \$500 donation in recognition of this support at the time and continues its support every year. In addition to volunteering for the annual Lobster Extravaganza (see above), they collect bicycles and boxes of toys for children at the Family Center. In 2016, the Fairfax Fraternal Order of Police presented Life with Cancer with a \$20,000 donation.
- *We Will Survive Cancer.* Members of We Will Survive Cancer raise money throughout the year to bring holiday cheer to families not able to participate in holiday gift-giving. In 2016, this group fulfilled holiday wish lists for nearly 20 families.
- *Virginia Run Turkey Trot.* Life with Cancer is now the exclusive beneficiary of an annual Turkey Trot 5K held in Centreville, Va. Community members started a small race locally; Life with Cancer did not benefit from the first few races, but eventually, more community members and major sponsors got on board. Now, in its 29th year, the race attracts approximately 4,000 participants. At one point, it was one of the top five largest races of its kind. Over the past 25 years, the race raised \$1.3 million; the 2016 race’s net was \$80,000.
- *Community-Based Restaurants.* Restaurants and other commercial establishments hold Life with Cancer fundraisers regularly that support our programs. “It’s important to work at finding the right philanthropic relationships in your community. These are committed relationships that will continue to donate, support, and help you organize your philanthropic programs. These donors are the ones who recognize that their contributions make lives better,” says Amy Richards, Leadership Giving Director for Life with Cancer.

in 2015 as its first psycho-oncologist to help provide therapy, mental health support, and medication management, as well as formalize program development.

“Patients and families need help selecting resources. Many patients come to us in the thick of their treatment when decisions are difficult,” says Rebecca McIntyre, MA, MEd, LCSW, OSW-C. McIntyre, Dr. Lolak, and other team members meet regularly and create emotional health treatment plans tailored to each patient’s needs. The plan—a menu of recommended support programs—is discussed with the patient to make choices easier.

Patients may also self-refer or be referred by community physician practices. Life with Cancer’s comprehensive website (lifewithcancer.org) is also a point of contact for patients and makes it easy to register for classes. The easy-to-navigate design helps cancer patients identify resources and support information.

Always Evolving, Always Responsive

Life with Cancer has been nominated as “Best Practice” by the CoC and the National Accreditation Program for Breast Centers

for its diverse programming. Our range of services fulfills some of the 2016 recommendations by the American Society of Clinical Oncology related to providing distress screening, psychosocial support, community resources, and nurse navigation. We are continually mindful of program size and the benefits and risks of larger versus smaller groups and programs. Some of our programs are intentionally limited to fewer than 15 patients to encourage greater connectivity and a more therapeutic space. We also support educational presentations and symposia that are designed to reach larger audiences. Life with Cancer programs include the following:

- Disease-specific support groups.
- Counseling for adults, children, and teens with cancer; children and teens with a loved one with cancer; couples and families.
- Supportive events for children and teens with cancer and for children and teens with a loved one with cancer.
- Classes on how to interpret laboratory tests and other diagnostic procedures; presurgical classes for breast cancer patients;

(continued on page 53)



Life with Cancer oncology nurse navigators and therapists in each of Inova's five community hospitals help reach cancer patients in the Washington, D.C., region.



Inova Health System

Inova is the Washington, D.C., region's leading not-for-profit healthcare system and serves more than 2 million people annually. The Inova Schar Cancer Institute provides expert cancer care at all Inova facilities, including the following:

- Inova Alexandria Hospital
- Inova Fair Oaks Medical Campus
- Inova Fairfax Medical Campus
- Inova Loudoun Hospital
- Inova Mount Vernon Hospital

Opening in June 2018, the Inova Schar Cancer Institute's new building will provide patient-centered care, expertise from national and internationally recognized cancer specialists, and translational research and clinical trials to patients at one central location. The collaborative approach to cancer care will provide seamless, coordinated treatment—translating to better outcomes.

(continued from page 51)

chemotherapy education; communication strategies for individuals and couples facing cancer, including sexual health and intimacy-related issues; insomnia and fatigue management; how to improve physical activity; and strategies for managing treatment-associated complications such as peripheral neuropathy and chronic pain, cognitive impairment, fatigue, body image concerns, depression, distress, and anxiety.

- Fitness and nutrition classes, including healthy cooking programs.
- Mind–body integrative-focused classes, such as Mind over Matter, Compassion Cultivation Training, Mindfulness-Based Cancer Recovery, meditation, yoga, Reiki, qi gong, tai chi, guided imagery, spirituality, and Healing Touch.
- Life with Cancer Connect, a triage line created as a critical touch point for patients and families looking for support. This central point of contact has streamlined access and care. 703-206-LIFE (5433).
- “Walking the Labyrinth,” an ancient meditation and mindfulness practice to promote healing and reduce stress. Our portable, indoor canvas labyrinth allows us to offer this ritual on a regular basis.
- Compassionate cultivation training is a unique curriculum implemented by Dr. Lolak that combines traditional contemplative practices, such as mindfulness-based stress reduction, with contemporary psychology and scientific research. This eight-week course helps participants develop compassion, empathy, and kindness for oneself and for others.
- Expressive therapeutic arts: art therapy, therapeutic dance, music, and journal therapy.
- Survivorship education and survivorship care planning.
- End-of-life and bereavement programs.
- Community outreach and engagement for underserved populations, including bilingual services and collaboration with community free health and mental health clinics.

Child, Adolescent, and Family Services

The child and adolescent program is a cornerstone of Life with Cancer and has been an integral part of programming from the start. Coping with a cancer diagnosis and treatment can be especially difficult for children and adolescents, whether they are coping with their own diagnosis or confronting a cancer diagnosis for someone they love. Life with Cancer’s experienced oncology therapists provide support to children, teens, and their families from diagnosis, during active treatment, and through survivorship or end of life and bereavement. Through counseling, art therapy, play therapy, and sand tray therapy, as well as education and discussion, our oncology therapists assist children and teens in gaining a deeper understanding of themselves and how cancer is affecting their lives. Relaxation techniques and other therapeutic interventions are integrated into the support provided to help children and teens manage anxiety and stress. Counseling support is also available to parents and caregivers who are navigating

The Power of a Single Seed

Life with Cancer grew out of personal loss and the desire to address the challenges one family encountered during their experience with cancer. During his wife’s illness, Nando Di Filippo found that there were no resources to help him and his children cope with their life-changing cancer experience. Determined to create change within the healthcare system, he envisioned a program that people dealing with cancer could turn to for support, information, and education from the moment they began their cancer journey. In 1988, Mr. Di Filippo made a generous donation to develop a program dedicated to supporting patients and families facing cancer and thus the seed was planted for Life with Cancer.

In September 1991, Life with Cancer, with three employees, met with patients in Fairfax Hospital and offered four groups and four classes. Flash forward to 2016 when Life with Cancer conducted 2,491 educational classes, groups, and wellness programs for adults, children, and adolescents, with 14,723 visitors. Oncology therapists and oncology nurse navigators provided 16,487 counseling or educational consultation sessions serving 14,438 people. The total number of participants in programs, classes, groups, and counseling services was 29,161, which accounted for 42,103 staff service hours.

The mission of Life with Cancer Mission: to enhance the quality of life of those affected by cancer by providing information, education, and support to children, adults, and families.

both the impact cancer is having on their family and on themselves.

“Life with Cancer provides a safe space for children, teens, and their families to express how they are feeling when a loved one is diagnosed with cancer or they are navigating grief,” says Jean McCaw, MA, ATR-BC, LCPAT, children and adolescent program coordinator. “Children will often share what they don’t talk about with anyone else. Our child and adolescent programs are designed to facilitate expression of feelings, provide a sense of release and relief, and decrease anxiety and general distress. These modalities lead to improved communication between a parent and child, as well as within the family system.”

Therapeutic support for children, teens, and parents addresses a range of psychological, emotional, spiritual, and social challenges that can result from illness, treatment, and hospital admissions. This support is available in outpatient clinics (including the long-

term survivorship clinic), where treatment is most often provided, and during inpatient hospital stays. Additional outpatient support for children, teens, parents, and other family members is available throughout the care continuum at the Life with Cancer Family Center.

The oncology therapists at Life with Cancer who work with children, teens, and their parents also create specialized programs for families with a child or teen in treatment and for families with an adult family member in treatment. These programs also include supporting families in survivorship or in their bereavement. Direct support for children is provided through the Curious About Cancer Support Group and Touchstone Grief Support Group. The Parenting Alone Grief Support group is for parents who have lost a spouse or partner and are raising children or teens alone.

Programs for children and adolescents in treatment and their families include a monthly parent oncology meeting, which provides opportunities for connection for both children and parents who share similar experiences and feelings. These meetings provide education and at times are more social and fun, focused on relaxation, rejuvenation, and connection. Programs include the following:

- Mother–Daughter Spa Night
- Father–Son Activity Night
- Specially crafted Halloween and holiday parties
- Kid & Sib Day for children in treatment and their siblings
- Surviving Cancer Competently Intervention Program, focused on teaching parents coping skills to better manage their child’s or teen’s cancer journey.

Of note, Life with Cancer’s “I’m Cured, Now What?” conference for teens and young adult survivors of childhood cancers has provided more than \$100,000 in college scholarships in 10 years.

Additional resources are available to parents and families through our website, including a resource called “Touching Grief: Frequently Asked Questions About Child and Adolescent Grief” for parents who are navigating the terminal illness or death of a loved one and supporting their child or teen through that process.

Life with Cancer partners with and connects families to a variety of supportive community foundations for practical supportive needs. Our services are also extended through a partnership with Fairfax County Public schools that makes Life with Cancer resources available to social workers, counselors, and teachers to provide additional support for children in treatment and those who have a family member with cancer. Among the support services we offer are cofacilitating grief support groups, providing information and support by phone, and meeting with school personnel to help plan ways to best support students who are impacted by cancer. This partnership provides a clear path for the school personnel to refer families to Life with Cancer for support.

Exercise is Everything

Many staff contribute to growing our innovative, evidence-based programming. In 2004, Susan Gilmore, MS, ACSM-CET, joined Life with Cancer to help meet the specialized exercise needs of patients. Susan, an American College of Sports Medicine–certified Cancer Exercise Trainer, developed classes with adapted movements to address balance issues, chemotherapy-related fatigue, weakness, muscle atrophy, and neuropathy-associated numbness and pain, among other conditions. She created patient assessment instruments and offers various levels of exercise to meet the changing physical capacities of patients. Susan also assesses and guides instructors on how to create and adapt classes such as Cross-Train Challenge, Functional Circuit Training, Barre Tone, and Barre-Pilates-Fuze for cancer patients and survivors and oversees our physical activity classes, including yoga (gentle, restorative, and Yin), tai chi, belly dancing, and Zumba. Research on the health benefits of exercise for those with cancer is well established, and our exercise program meets this critical need.

Mind-Body Connection

Through education and evidence-based practices, Life with Cancer helps patients and families disrupt the negative cycle of anxiety and uncertainty associated with a cancer diagnosis. Clinical interventions, such as the 5-week Mind over Matter series and the 6-week Mindfulness-Based Cancer Recovery program, use traditional cognitive behavioral strategies. Mindfulness-based stress reduction practices help participants learn how to manage anxious thoughts and reach a more relaxed, calm state. Group members engage in practices that promote a greater understanding of the mind–body connection and are guided through exercises that empower them to use their bodies and minds to induce the relaxation response and achieve equanimity and an overall sense of well-being.

Research consistently supports that mindfulness-based practices can significantly improve psychological and physical functioning in cancer patients by lowering depression and anxiety and reducing symptomatology such as fatigue, pain, and insomnia. These practices also enhance positive biological outcomes, including lowering levels of stress hormones and inflammatory markers, thereby improving immune function. Controlling stress and anxiety permits participants to become actively involved in their own healing and recovery, thus facilitating a sense of mastery and promoting healthier functioning.

Planning Ahead—Help with Tough Conversations

This series on death and dying covers information about how the body dies, how to create and leave a legacy, estate and funeral planning, and writing wills. It prepares patients and families for many end-of-life considerations. The emotional benefits of discussing death are now well established by research and better accepted by most patients.

Research Contributions

Life with Cancer staff have been involved in research studies in such areas as distress screening, effectiveness of mind–body techniques, sexual health, insomnia, and understanding grief. Currently, Inova and Life with Cancer, in collaboration with The James at Ohio State University, are engaged in a biobehavioral study based upon the work of Barbara Andersen, PhD, around biobehavioral interventions that decrease psychological symptoms and improve health to reduce the burden of cancer in patients, their families, and the healthcare system. In addition, many staff members have written articles on a variety of psychosocial issues in oncology. Going forward, Life with Cancer intends to substantially expand its research capabilities.

Philanthropy: Fundraising Traditions Set Cornerstones for Success

Seventy percent of Life with Cancer’s operating budget is supported through philanthropy, primarily from community contributions; 30 percent of the operating budget is supported by the Inova Health System. Longstanding community support enables Life with Cancer to offer and sustain free services. “Our fundraising model hasn’t changed drastically. We couldn’t exist without our strong community support and our dedicated volunteers,” explains Amy Richards, Leadership Giving Director for Life with Cancer. Though a handful of large Life with Cancer fundraisers are enormously successful from year to year, Amy emphasizes that all donations make a difference and are always 100 percent donor driven. “All funds, whether from galas, golf outings, or 5K runs, go directly to whichever program or general fund the donor wants to support within Life with Cancer,” says Richards. “Life with Cancer supports our neighbors and in turn our community supports us. We are grateful for all their support.” Turn to page 45 for a look at some of Life with Cancer’s many fundraising activities.

Volunteers: Place Them Where They Enjoy Working


“One outstanding characteristic of Life with Cancer’s volunteers is the remarkable expertise they contribute,” explains Catherine Intartaglia, community affairs and volunteer coordinator for Life with Cancer. Volunteers make our unique and numerous programming options possible. For example, 60 community Reiki masters, who receive training specific to cancer patients, volunteer their time to offer this healing, stress reduction, and relaxation technique to Life with Cancer patients and family members. Two sessions are held each month at the Family Center, and 30 patients now participate in monthly sessions at the Inova Fair Oaks Medical Campus. One patient, who had received Reiki at Life with Cancer, became a Reiki master and returned to Life with Cancer to volunteer. “Our patients really respond to this program,” says Intartaglia. Women recovering from breast cancer surgery reported having better range of motion and less pain. At the Inova Fairfax Medical Campus and Inova Loudon Hospital, nurse volunteers trained in Healing Touch offer this energy therapy to interested patients.

Intartaglia creates job descriptions with clear expectations for her volunteer pool and then hires and trains these individuals. Some of Life with Cancer’s 150 volunteers help with logistics for fitness programs, including setting up the room, checking in participants, managing paperwork and waivers, and assisting the instructors. Others provide the many hands that are needed for Life with Cancer’s fundraising events. One volunteer distributes the distress screening on the oncology inpatient unit at the Inova Fairfax Medical Campus, helping Life with Cancer staff identify patients who could benefit from psychosocial intervention or education. Catherine would like to train more volunteers to perform this task, which requires someone with objectivity and good boundaries. Help with community outreach for health fairs and other events for which less training is necessary is another opportunity for volunteers. “I pay attention to the reasons why people volunteer and what they find fulfilling, so we can keep them for a long time,” says Intartaglia.

Looking Ahead: More Programs, More Innovation

Moving forward, we are developing new programs to meet the educational and support needs of our population in a rapidly changing oncology care environment. We hope to attract more men to our psychosocial services, build a nutrition program, and develop additional innovative programs for teens. We plan to offer more intentionally structured, evidence-based programs—those with a defined beginning, middle, and end, which enables participants to learn information, practice skills, manage symptoms, and feel empowered to get back to engaging in life.

As the Inova Schar Cancer Institute grows, it will be important that directors, managers, or staff of psychosocial support programs continue to have a seat at every table. Participation and collaboration in committees and meetings, such as the ethics committees, tumor boards, cancer committees, patient experience meetings, development meetings, executive council meetings, and clinical operation meetings, are critical to assure the biopsychosocial–spiritual needs of patients remain at the forefront. Our observations, knowledge, and experience as clinicians are critical as we flesh out and define best practices for integrative oncology care, a key component in the personalized medicine approach that ensures the best outcomes for our patients.

Though it is daunting to consider creating a psychosocial services support program for cancer care, it is possible for most community cancer care centers. Salaries are a big part of the initial expenditure. With \$250,000, two staff can get a program started. A philanthropic gift of approximately \$1 million is needed for a larger program. You will need office space and equipment, a website, and marketing materials to promote services. Start small, with a few services offered once a month and a newsletter or announcement offering resources. And grow your base: “Having an engaged group of volunteers and board members is essential,” says Amy Richards, Leadership Giving Director for Life with Cancer. 

Sage Bolte, PhD, MSW, OSW-C, CST, is executive director, Life with Cancer and Patient Experience, Inova Schar Cancer Institute, Fairfax, Va.



Mind, Body, and Spirit

How robust integrative and complementary services can bring an entire cancer program together

WellStar Health System is the largest health system in Georgia, with 11 inpatient hospitals. It is a not-for-profit organization recognized nationally for its innovative care models, which are designed to improve quality and access to healthcare. Several years ago, WellStar made a strategic decision to centralize administration of WellStar Health System cancer services by creating a system-wide Cancer Network. The goal of this initiative was to ensure that all cancer services provided throughout the network are provided in a consistent, high-reliability manner. At that time, oncology-related programs and services at the network's largest facility, WellStar Kennestone Hospital, were spread across the campus in different locations, and supportive care services were not always easy to access. As the cancer program grew, cancer network leaders recognized the need for change, and a new goal was created: to provide an environment focused on the needs of the whole patient—mind, body, and spirit.

In the Beginning

The vision for expanding the cancer program's scope and consolidating its services for patient convenience was first explored in 2011 during the planning stages for construction of an additional inpatient tower. This vision became a reality in late 2013 when the new Blue Tower and bridge opened. The oncology inpatient unit was moved to the first floor of this tower and a bridge connected inpatient and outpatient cancer care areas on

During the planning stages for the outpatient cancer center, it was quickly recognized that the space should be designed to be patient friendly, and cancer network leaders sought to find best practices in the industry.

the second floor. The bridge allowed staff, such as patient navigators, to get from outpatient areas to the inpatient unit to see a patient in a very short walk. Additionally, the bridge made it easier to transport inpatients needing radiation therapy.

During the planning stages for the outpatient cancer center, it was quickly recognized that the space should be designed to be patient friendly, and cancer network leaders sought to find best practices in the industry. To that end, project leaders consulted with Planetree, a global leader in advancing person-centered care to provide an organizational assessment report with recommendations. After reviewing literature and making site visits to cancer centers with similar vision, the clinical director, operations director, and clinical educator completed the Planetree Coordinator Ori-



Left upper: Illuminations by Borelli's, a medical hair loss boutique. Right upper: The Dana and David and Parks Resource Center where volunteers assist patients and caregivers with online and print resources. Right lower: Welcome Center with fireplace and comfortable seating, a place to wait or rest between appointments. Left lower: Manning Wellness Kitchen where patients and caregivers can participate in cooking demonstrations and nutritional education.

entation and began to incorporate many Planetree concepts during the active planning phase over the next 2 years, including the following:

- Dignity and choice
- The importance of social support
- Patient education and access
- A healing environment
- Nutritional and nurturing aspects of food
- An arts program
- Spirituality
- Human touch
- Integrative therapies
- Healthy communities.

Cancer Network leaders selected an architectural firm, CDH Partners, whose goal is “to engage, inspire, and enhance the human experience by creating designs that connect a building’s purpose, function, and context to those who use it” to work closely with the cancer program’s Patient Family Advisory Board, as well as with clinical, medical, facilities, and administrative staff. This process resulted in a new design for space, equipment and furniture, clinical appointments, programs, and services, creating an environment for comprehensive and seamless care.

The physical space for the outpatient cancer care services, which consisted of two older buildings, was redesigned inside and out. The planning team worked very closely with the architects to ensure that the new space would be built around the patient wellness and to meet the vision of world-class cancer care.

After years of planning and more than \$11 million in renovations, the new cancer center finally opened in late 2015. To see all of the development and planning come together was extremely rewarding to all those directly involved on the project. Today WellStar Cancer Center at Kennestone Hospital is recognized as a “hub for healing,” with new integrative medicine services and robust support services that improve the overall patient care experience.

Our New Cancer Center At-a-Glance

WellStar Cancer Center is composed of two connected medical office buildings. One wing of the Cancer Center houses the outpatient infusion center, a medical imaging suite, a medical oncology private practice, and the STAT (Specialty Teams and Treatments) clinic.

The state-of-the-art outpatient infusion center occupies 6,600 square feet. There are six treatment bays with four semi-private patient areas and one nurse assigned to each bay. There patients receive chemotherapy, biotherapy/targeted agents, blood transfusions, or other infusions by professional nursing staff. In this department, 100 percent of eligible nurses have earned OCN credentials.

Based on research and feedback from patients, Cancer Network leaders wanted to make sure that this space offered a variety of amenities that allowed patients to control their environment. Each patient has an automatic reclining chair, a personal television with headset option, adjustable lighting, and storage space for personal belongings. Guest seating for one friend or family member



Cancer Center volunteers, patient and family advisory board (PFAB) and staff during the open house for community and team members.

staying with the person receiving treatment was a must-have.

Visits from therapy dogs, a complimentary tea cart staffed by volunteers, and headphones for calming or meditative music are also offered to promote comfort during each visit. Community organizations regularly donate snacks and handmade hats, scarves, and lap blankets. These items are delivered in decorative gift bags and often include an inspirational message to let patients know they are not on this cancer journey alone.

The imaging center is conveniently located near departments where cancer patients have other appointments, minimizing wayfinding issues associated with entering the main hospital for registration and diagnostic radiology appointments. Walk-ins are accepted for X-rays; positron emission tomography-computed tomography, nuclear medicine imaging, and computed tomography exams are by appointment.

Because not all advances in medicine involve the latest drugs or technology, for WellStar Cancer Center, advancing medicine

meant enhancing access to care and providing an innovative multidisciplinary approach. The STAT Clinic, across the hall from the imaging suite, is where an entire team of dedicated specialists can see patients in one place during one appointment. For patients (and families of patients) diagnosed with or suspected of having thoracic or prostate cancer, the thoracic STAT Clinic means less waiting and worrying. Patients have access to thoracic surgeons, pulmonologists, medical oncologists, radiation oncologists, nurse navigators, clinical psychologists, social workers, chaplains, and registered dietitians. The prostate STAT Clinic offers patients consults with a urologist, radiation oncologist, and nurse navigator to determine the best course of care based on their individual presentation. Currently, throughout WellStar, we have thoracic, prostate, and breast STAT clinics that meet regularly. Depending on the volume of the particular tumor site, STAT clinics are offered as frequently as twice per week. When a patient is referred to one of the STAT Clinics, the nurse navigator coordinates all tests and

appointments. Based on available test results and information from referring physicians, the nurse navigator and lead physician will decide whether the patient is to see one or several disciplines of physicians as indicated.

Furthering our dedication to multidisciplinary care, Northwest Georgia Oncology Centers, a private-practice, medical oncology practice of 20 physicians, has its largest office and infusion center located on the second level of the WellStar Cancer Center. The Cancer Center also provides meeting spaces, including the Northwest Georgia Oncology Centers' conference center space located at entry level. These spaces provide a forum for clinical and ancillary staff to meet and discuss patient cases during tumor conferences and the space is also used by clinical and administrative staff to set, monitor, and track progress of cancer program goals. The meeting rooms are equipped with technology that facilitates local presentations, as well as remote access to physicians and staff off-site.

While planning for supportive services in the new cancer center, Cancer Network leaders and Cancer Center staff looked at adding programs and services that had evidence to be beneficial to cancer patients.

A Welcome Center and Garden of Courage separate the two wings of the WellStar Cancer Center. The gas fireplace is a focal point for the Welcome Center and complements the environment created by the dedicated volunteers at the entryway, who extend a warm welcome to each person entering the building. The Cancer Center's guest relations representative attends new volunteer orientation to recruit specifically for the Cancer Center. The volunteers who select the Cancer Center as their location for service during volunteer orientation complete WellStar Volunteer Training for Kennestone Hospital and then receive orientation specific to the Cancer Center. Those volunteering in the Resource Center also complete American Cancer Society Volunteer Training so they are knowledgeable about WellStar, community, and American Cancer Society resources and programs. As recommended by the Patient and Family Advisory Board, none of the waiting areas have televisions. Instead, digital signage promotes programs and services offered at the Cancer Center.

During the Cancer Center renovation, the hospital system's foundation, the WellStar Foundation, was able to obtain generous donors who provided support for the outdoor Garden of Courage. Foundation funding for the Cancer Center's outdoor courtyard allowed for more than 700 new plants and trees, paint, refurbishment of existing gazebos, new lighting, donor signage, and,

most important, a new polished brass bell. On the last day of treatment, patients ring the bell as their family, staff, and visitors celebrate this milestone.

Integrative and Complementary Therapies

While planning for supportive services in the new cancer center, Cancer Network leaders and Cancer Center staff looked at adding programs and services that had evidence to be beneficial to cancer patients. According to the National Center for Complementary and Integrative Health Clinical Digest,¹ a monthly newsletter of the National Institutes of Health, several integrative and complementary therapies can help cancer patients with side effects of their treatment. Below is a list of common mind/body interventions and what the evidence suggests:

- **Acupuncture.** Evidence suggests that acupuncture can help cancer patients with chemotherapy-induced nausea and vomiting.
- **Massage therapy.** A limited number of studies suggest that massage therapy may help to relieve cancer-related symptoms (pain, nausea, anxiety, and even depression). However, the National Center for Complementary and Integrative Health indicates that research is still lacking on the benefits of massage for oncology patients.
- **Mindfulness stress reduction.** Studies suggest that guided meditation can help patients with stress and anxiety and may promote better sleep for cancer patients.
- **Yoga.** Though there are not many studies on the benefits of yoga for cancer patients, early evidence suggests that yoga may alleviate anxiety, depression, and emotional distress and lower stress levels in people with cancer. Yoga has also shown to be effective at alleviating fatigue in breast cancer patients and survivors.

The second wing of the Cancer Center offers programs and services that extend the "mind, body, and spirit" concept of care. The team of professionals connecting patients to these services work in the Center for Survivorship and Support, also located in the second wing of the Cancer Center. A team of nurse navigators, social workers, clinical psychologists, and dietitians understand that people living with cancer have needs that include both medical care and other physical and emotional challenges. With these supportive care resources now located in one physical space, the team can work much more effectively to coordinate patient care.

The Center for Survivorship and Support offers individual and group sessions, including but not limited to support groups, preoperative classes, individual appointments, and mindfulness-based stress reduction sessions. Also located in the Center for Survivorship and Support are screening programs, such as L-Dex for lymphedema, which provide patients ongoing support through survivorship and enhance their ability to get preventative care.

Although patients often asked what they can do to be healthier, the Cancer Center did not offer options for exercise prior to the renovation. To meet this patient need, the Cancer Center opened a Wellness Studio, which serves as a multipurpose room. Here

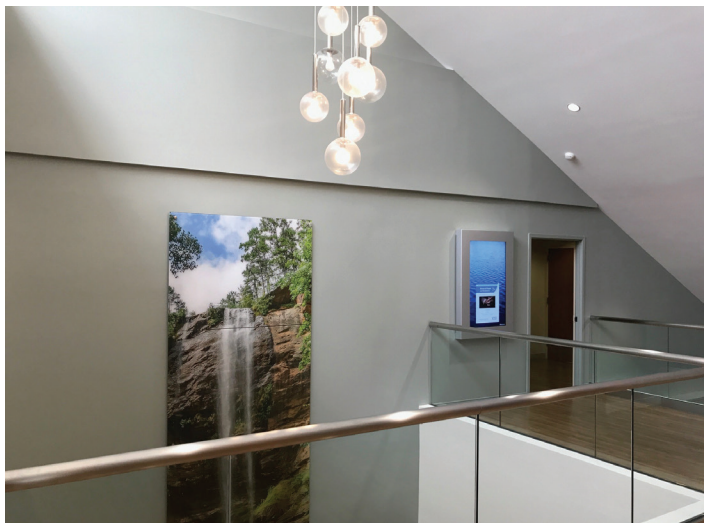
fitness instructors trained to work with cancer patients lead classes in tai chi, stretching, yoga, and low-impact resistance training classes several times each week. Stress-relieving activities include painting, jewelry making, and cookie decorating. This multipurpose room is also used for departmental meetings, Cancer Committee meetings, and disease site-specific subcommittee meetings, with Skype access for other facilities to participate. In addition, the Wellness Studio is where patient support groups and the Patient and Family Advisory Board meet and where staff attend classes for learning to administer chemotherapy and/or preparing for the oncology certified nurse exam.

Another key component of the renovation was the addition of a Resource Center, an interactive space for patients and their families and friends. Here kiosks—in partnership with the American Cancer Society—provide immediate and easy access to clinical information and community resources. Shelves of resources and brochure displays help patients and the general public learn more about prevention, screening, diagnosis, treatment, and life after cancer.

Across from the Resource Center are the Manning Wellness Kitchen and Calm Water Café. The Manning family recognized that time around the kitchen table is important to healing, and their commitment to sharing this practice was realized with a fully equipped demonstration kitchen and dining area, where patients and the general public can participate in cooking demonstrations. These demonstrations emphasize healthy and appealing meal selections for those with cancer, as well as anyone seeking options for improving their health through diet. On a recommendation by the Patient and Family Advisory Board, cooking demonstrations are carefully vetted, because some food odors are offensive to patients receiving cancer treatment. For that same reason, industrial fans in the demo kitchen keep food aromas to a minimum, and the Calm Water Café offers a “grab-and-go” menu made with fresh and natural ingredients. Patients, visitors, and staff can mingle while sipping on a healthy smoothie, and physicians can catch a bite between patients. Located just a few steps away from the healing garden, if the weather is nice, a meal can be enjoyed outside.

A short walk across the hall, patients, staff, and visitors are welcome to enter the Gray Chapel named in honor of Rick Gray, MD. Gray practiced medical oncology with Northwest Georgia Oncology Centers from 1987 to 2014 before succumbing to cancer himself in 2015 and was known for his caring and compassionate demeanor and dedication to his faith. In addition to a weekly nondenominational healing service, prayer cards are available for anyone to request prayers for their own concerns or on behalf of another. All are invited to use this space to reflect in an undisturbed, serene setting.

Upstairs are the offices of the board-certified genetic counselors. The Center for Genetics is one of the busiest genetics programs in the Southeast. Through a one-on-one risk evaluation with patients and their family members, these



Right upper: Foyer connecting patients with the Wellness Studio, The Center for Genetics, and the Healing Arts Lobby. Right middle: The Gray Chapel which provides staff, patients and families a place for prayer and meditation. Right lower: The Garden of Courage, a beautiful outdoor space with polished brass bell that celebrates patient's strides against cancer.

Another takeaway is that patients are the best source for knowing what is valuable to them—as human beings as well as patients.



Left upper: Healing Arts Lobby for retail services: Illuminations' hair loss boutique, Buckhead Acupuncture and Lacey's post-mastectomy care center. Left lower: Cancer Support Services team at annual survivorship celebration. L to R: Leena Nehru, MSW; Susan Willard, RN Navigator; Jennifer Kilkus, PhD; Michelle Guibault, RN Navigator; Nancy Page, RN Navigator; Sara Owens, RN Navigator; Lisa Sherman, RN Navigator; Paula Garcias, Registration; Glinda Bellamy, RN Navigator; Barbara Wilson, RN Director; Rachel White, RD.

counselors determine the need for testing by looking at specific patient and family factors. If testing is performed, genetic counselors will incorporate results into the patient's medical management and assist the patient, family, and medical team in making future treatment decisions.

A myriad of professionals devoted to improving symptoms and side effects of cancer lease space in the Cancer Center area. For example, patients seeking nonpharmacologic interventions for symptom management can be treated by acupuncturists who apply principles of Chinese medicine. The acupuncturist is an independent practitioner who is licensed and works with patients by referral from a physician or by self-referral. The cancer program medical director provided guidance in choosing the right holistic practitioners for the cancer center to ensure that their philosophies and therapies were not in opposition to traditional medicine. A certified breast prosthesis fitter provides postmastectomy care. Women are fitted for bras, breast prostheses, swimwear, and other garments in a private setting with personal attention from this specialist. Illuminations, a salon and boutique, offers a variety of solutions to one of the most distressing side effects of cancer treatment—hair loss—including wigs, hats, scarves, and turbans. Patients who are interested in cryotherapy (Cold Caps) to prevent hair loss have the option of bringing the necessary supplies in and enlisting family and friends to assist with the process. A staff member with firsthand experience using cryotherapy for hair loss is available for advice and to assist patients in determining whether this option is right for them.

Key Takeaways

Being diagnosed with cancer is often referred to as a life-threatening or, at best, a life-changing event. Patients walking into the WellStar Cancer Center at Kenestone Hospital often describe the experience as a mind-changing event. Patients frequently say that the staff and services available in the Cancer Center have decreased their stress levels because they feel the support of staff and appreciate access to all of the mind, body, and spirit services offered to help them manage the many challenges of cancer.

When Cancer Network leaders considered the Cancer Center pre- and post-renovation, a few key takeaways stood out. First, when support services are conveniently available, patients are more likely to be aware of services and use them. Secondly, if the physical environment is inviting and soothing, it can influence the way a patient feels and go a long way in promoting health and well-being.

Another takeaway is that patients are the best source for knowing what is valuable to them—as human beings as well as patients. Without the involvement and input of the Patient and Family Advisory Board, we would not have been as successful in building a space that meets both staff needs and the needs of patients and their families.

Working in concert with the Patient and Family Advisory Board, the Cancer Center achieved true integration of mind, body, and spirit.

Finally, in retrospect, Cancer Network leaders were astonished to realize that though a great clinical cancer program existed prerenovation, the tenets of treating the “whole” patient were not actually being met. By bringing these vital programs and services together in a space convenient to patients, ensuring that patients and families are made aware of them, and then streamlining access to these programs and services has made the Cancer Center exponentially more successful. If done right, a well-planned Cancer Center can truly take a cancer program to the next level.



Barbara J. Wilson is director of Oncology Professional Practice; Sara Owens is breast nurse navigator; and Chad Schaeffer, MS, FACHE, is vice president, Oncology Service Line, WellStar Cancer Network, Marietta, Ga.

Reference

1. National Center for Complementary and Integrative Health. Complementary and integrative approaches for cancer symptoms and treatment side effects: what the science says. *NCCIH Clinical Digest*. May 2015. Available online at: nccih.nih.gov/health/providers/digest/cancer. Last accessed January 31, 2018.

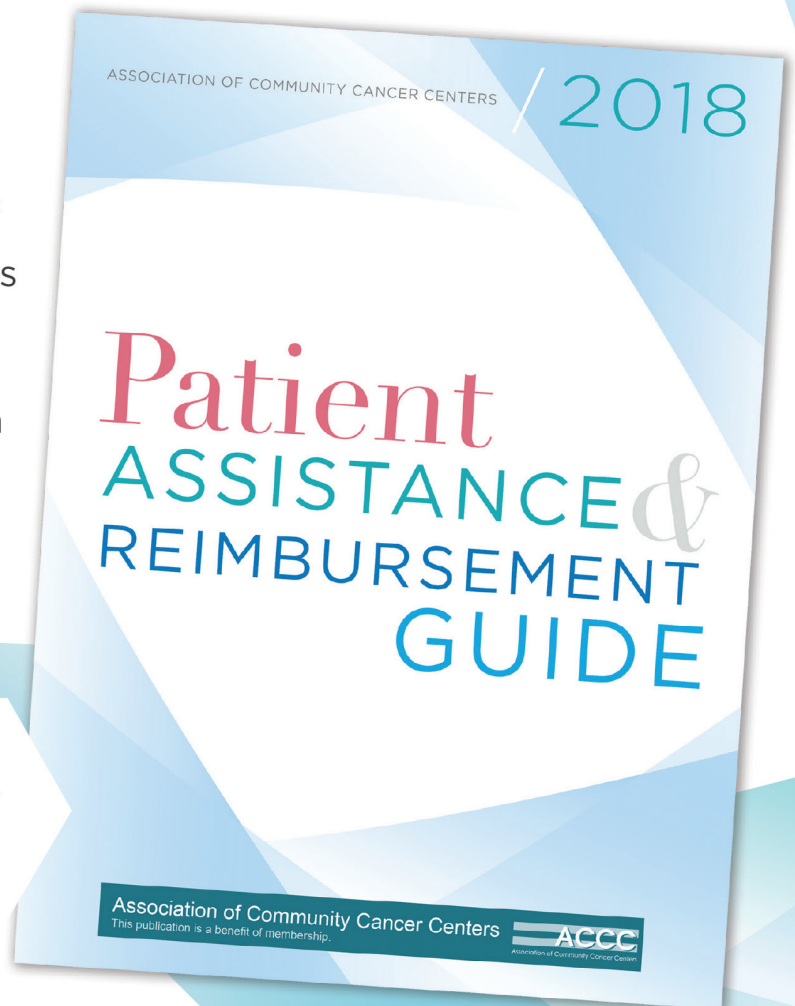
About the WellStar Kennestone Hospital Cancer Program

WellStar Kennestone Hospital is a 633-bed community hospital located in Marietta, Ga. Kennestone is part of the WellStar North Cancer Network, which includes Kennestone and five other hospitals: WellStar Cobb Hospital, WellStar Douglas Hospital, WellStar Paulding Hospital, WellStar North Fulton Hospital, and WellStar Windy Hill Hospital. The program is accredited as a Cancer Network by the Commission on Cancer. The breast program is also accredited by the National Accreditation Program for Breast Centers. Together, the North Network sees about 4,500 new analytic cancer cases annually. There are tumor-specific subcommittees for breast, lung, gastrointestinal, genitourinary, gynecologic, neuro, and melanoma. These subcommittees are physician-led teams and, along with allied healthcare professionals, are focused on improving quality and safety in their respective areas of cancer care.

Help patients find the financial assistance they need.

Updated four times each year, the **ACCC Patient Assistance & Reimbursement Guide** provides direct access to the latest pharmaceutical and foundation patient assistance and co-pay program information.

Download the most up-to-date version at acc-cancer.org/PatientAssistanceGuide



The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the multidisciplinary cancer team. Founded in 1974, ACCC provides a multidisciplinary, how-to perspective to help every member of the cancer care team address gaps in care delivery and coordination, translate cutting-edge information into real-world practice, and optimize patient outcomes.

Not a member? Join today at acc-cancer.org/membership or email membership@acc-cancer.org. For more information, visit the ACCC website at acc-cancer.org. Follow us on Facebook, Twitter, LinkedIn, and read our ACCCBuzz blog.

action

ACCC Welcomes its Newest Members

UVM Medical Center University of Vermont Cancer Center

Burlington, Vt.
Delegate Rep: Katherine Sanborn Michaud
Website: uvmhealth.org/medcenter

Trinity Regional Medical Center Trinity Cancer Center

Fort Dodge, Iowa
Delegate Rep: Mrs. Christen Sewell, MHA, BS, RT (R)(T)
Website: unitypoint.org/fortdodge/cancer-center

McLaren Bay Karmanos Cancer Center

Bay City, Mich.
Delegate Rep: Nancy King, RN, BSN
Website: mclaren.org/bayregion

Georgia Cancer Center for Excellence Grady Health System

Atlanta, Ga.
Delegate Rep: Darica Michelle Flood, MHA, MBA
Website: gradycancer.org

Shaw Cancer Center

Edwards, Colo.
Delegate Rep: Stacy Toyama
Website: vailhealth.org/services/cancer-diagnostics-care/about-shaw-cancer-center

Oncology Reimbursement Meetings—Free to ACCC Members

These meetings help you navigate the annual changes in oncology reimbursement and regulations, provide tools to strengthen your program's operations, and accelerate your knowledge on which measures you can take now—and down the road—to succeed in this rapidly changing landscape.

All members of the cancer care team who deal with oncology business and reimbursement will benefit from this meeting. Gain a comprehensive perspective in just one day of sessions:

- Review the latest trends in oncology coding and billing based on the 2018 Medicare Final Rules
- Assess financial strategies to track and improve the financial health of your cancer program
- Gain insight to upcoming coding and reimbursement challenges related to financial counseling, compliance, and authorizations in medical and radiation oncology
- Identify opportunities to improve the financial navigation services at your cancer program
- Investigate the impact of federal health policies on your cancer program.

Free to ACCC members; non-members are invited to attend at the low registration rate of \$149.

Save the Dates!

April 10, 2018

Princeton, N.J.
8:00 AM to 3:45 PM (Eastern Daylight Time)

May 3, 2018

Charleston, W.V.
8:00 AM to 3:45 PM (Eastern Daylight Time)

June 19, 2018

Baton Rouge, La.
8:00 AM to 3:45 PM (Central Daylight Time)

Dietitian as Navigator A Winning Combination

BY KELAY E. TRENTHAM, MS, RDN, CSO



In cancer care, the use of patient navigators has grown substantially over the past decade. In 2012, the American College of Surgeons' Commission on Cancer added Standard 3.1 requiring that accredited programs have a patient navigation process in place. Though the navigator's role and responsibilities may vary from institution to institution, clinical navigators typically:

- Assess patients' clinical, financial, spiritual, and other needs
- Ensure that patients are referred to appropriate supportive care such as financial counselors, social workers or psychologists, dietitian or nutritionists, palliative care providers, and rehab services
- Provide needed patient education on the disease and its treatment
- Assist patients in overcoming barriers to care
- Assist patients and families with managing complex social, cultural, developmental, cognitive, and economic circumstances
- Assist in care transitions, discharges, and advanced care planning.

Given these responsibilities, it may come as no surprise that nurses and social workers are often in navigator roles. Some cancer programs may also employ nonclinical navigators (or lay navigators) who assist patients with some services, as is the case with the American Cancer Society's resource navigators, who educate patients about the American Cancer Society and other

community resources. Patient navigation is usually a team effort where the work of various disciplines coalesces around a single point of contact for care coordination. For example, the navigator may be the patient's central connection even though she or he refers patients to physical therapists or dietitians for specialized care.

For diagnoses that require intensive nutritional support, such as head and neck, esophageal, or gastric cancer, a registered dietitian nutritionist can effectively serve as a patient's principal navigator, because these patients may see the registered dietitian nutritionist as often, if not more often, than other team members throughout the course of treatment as well as posttreatment.

In initial medical and radiation oncology consults, these patients are often told that they will need a feeding tube. Prior to receiving feeding tube education, patients may have many concerns such as that the tube is very large and cumbersome, that it might impede normal daily activities, that tube placement is permanent, or that they or their caregiver(s) will not be able to learn how to use it. Meeting with a registered dietitian nutritionist for immediate education about the logistics of having a feeding tube can allay any fears and concerns about this component of their care plan and reduce distress. In addition, the registered dietitian nutritionist can reassure patients and caregivers that he or she is available to assist with any questions about using the tube throughout the course of

treatment. Further, registered dietitian nutritionist navigators can assure patients that their experience and training places them in a unique position to best advocate for patients with respect to nutrition support issues.

The registered dietitian nutritionist's knowledge base makes this member of the cancer care team an excellent fit for ensuring coordination of care with a patient's home infusion agency. In addition to regular monitoring of nutritional status and the provision of nutrition support, a registered dietitian nutritionist navigator can:

- Work with the medical team to ensure proper documentation so that enteral feedings are covered by insurance
- Assist patients with locating donated tube-feeding supplies and formula in the event of limited or a lack of coverage
- Work with pharmacy services to get medications converted to crushable or liquid forms for use in feeding tubes.

In addition, the registered dietitian nutritionist navigator would continue to see the patient regularly during the transition from tube feeding back to an oral diet, coordinating care with the speech therapist or surgeon as needed. For example, after gastrectomy or esophagectomy, patients experience significant changes in oral diet tolerance and may require considerable education and coaching to adapt to their "new normal." Patients may also experience nutritional issues over the long run, which the registered dietitian nutritionist can monitor and/or preempt.




Kelay E. Trentham, MS, RDN, CSO, counsels patients regarding nutrition during cancer treatment.

Much like the nurse or social worker navigator, the registered dietitian nutritionist navigator would refer patients to other disciplines when needed, such as to an RN for education about port placement, to a pharmacist for questions about chemotherapy or medications, to a social worker or financial counselor for financial concerns, or to rehabilitation services (speech/swallow, physical, and/or lymphedema therapy). For some patients, intensive nutrition support may be required from before treatment until

long after treatment is completed, making it a primary component of care that the registered dietitian nutritionist is best equipped to navigate.

At its best, patient navigation should be designed to ensure that patients receive individualized, timely, appropriate, and high-quality care from the entire multidisciplinary team. Excellent care is always a team effort best orchestrated by a strong advocate and leader. For cancer patients requiring intensive nutrition support, having an RDN

serve as the patient's navigator and central care coordinator can be a winning combination, improving care as well as the patient experience. 

Kelay E. Trentham, MS, RDN, CSO, is a past chair of the Oncology Nutrition Dietetic Practice Group of the Academy of Nutrition and Dietetics. She is currently an oncology dietitian at MultiCare Regional Cancer Center in Tacoma, Wash.

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